

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 06/13/2017 Are you an AUM student? YES NO Student ID # _____

Name: Andrea Robertsen

Social Security Number: 410-73-9815 Birth Date 02/01/1993

Local Phone Number: 615-516-8337 Alternate Number: 615-860-8962

Local Address: 307 Azalea Park Lane Box Number _____

City: Montgomery State: AL Zip Code: 36106

Permanent Address: 307 Hickory Chase Ct.

City: Madison State: TN Zip Code: 37115

Marital Status (Please Circle): Single Married Divorced Widowed Other _____

Sex (Please Circle): Female Male _____

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: Vanderbilt university Work #: _____

Parent's or Spouse's Name (Circle which) _____ Phone #: _____

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Linda Hamer Relationship: Mother Phone #: 615-972-8737

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other Self

INSURANCE INFORMATION

Do you have health insurance? YES NO

If yes, please give your card to the receptionist in order for a copy to be made for your chart.

Insurance Company Blue cross Blue shield of illinois Name on Card Linda F. Crawford

Policy Number PAS 835026170 Group Number 099964

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Andrea Robertson Date of Birth 02 / 01 / 1993

General Consent for Treatment

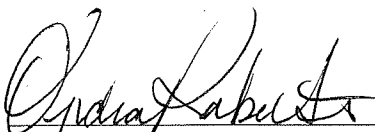
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.



Signature of Patient

06 / 13 / 2017
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

Auburn Montgomery Student Health Services

PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize Auburn Montgomery Student Health Services (AUSHS) to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of AMSHS practice.

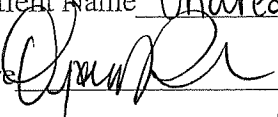
I have also been informed of and given a copy of AMSHS *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that AMSHS reserves the right to change the terms of this from time to time and that I may contact AMSHS at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that AMSHS is not required to agree to these requested restrictions. However, if AMSHS does agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 13th day of June 20 17.

Print Patient Name Andrea Robertson

Signature 

Relationship to Patient self

AUM Student Health Services
Medical Information Release Form
(HIPPA Release Form)

Name: Andrea Robertson Date of Birth 02/01/1993

Release of Information

☒ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

☐ Spouse: _____

☐ Child(ren): _____

☒ Other: Linda Hamer (mother)

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☒ my cell number: (615)-516-8337

If unable to reach me:

☒ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (day or days) Monday - Friday between 8am and 5pm times.

Signed: _____

Date: 06/13/2017