

AUM STUDENT HEALTH CENTER

Mitchell, Ali
9am

PATIENT INFORMATION (PLEASE PRINT)

Date: 6-15-17 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Ali Mitchell

Social Security Number: 424-43-5329 Birth Date: 7-31-1995

Local Phone Number: 251-767-8229 Alternate Number: _____

Local Address: 101 Meadow Wood Box Number: _____

City: Netumpka State: Al Zip Code: 36093

Permanent Address: 602 Barnstons Ct

City: Birmingham State: Al Zip Code: 35242

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

Sex (Please Circle): ☐ Male ☒ Female

Primary Physician: Audra Kerns PA City: Montgomery Phone #: 530-16387

Patient's Employer: Wal-Mart Pharmacy Work #: 334-5107-3077

☒ Parent's or Spouse's Name (Circle which) Mari Mitchell Phone #: 505-803-3790

☒ Parent's or Spouse's Employer: Bain Cochran Construction Work #: _____

Emergency Contact: Mari Mitchell Relationship: Mom Phone #: 505-803-3790

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

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 _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Ali Mitchell Date of Birth 7/31/1995

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

6/15/17
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.

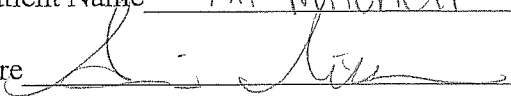
I have also been informed of and given a copy of AMSHS *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that AMSHS reserves the right to change the terms of this from time to 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 15 day of June 2017.

Print Patient Name Ali Mitchell

Signature 

Relationship to Patient Patient

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

Name: Ali Mitchell Date of Birth 7/31/1995

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: pharmacy or myself

☐ 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: (251)-767-8279

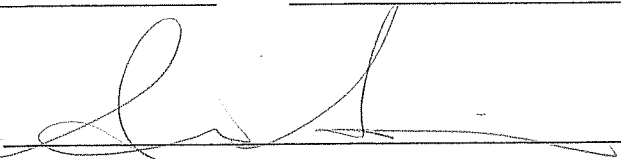
If unable to reach me:

☒ 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) _____ between
_____ and _____ times.

Signed: 

Date: 6/15/17

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Ali Mitchell

DATE OF BIRTH 7 / 31 / 95
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Ali Mitchell

DATE 10-15-17

FORM REVIEWED BY _____

DATE _____

Did you bring your immunization record card with you?

yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.