

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 10/27/10

Are you an AUM student? ☒ YES ☐ NO

Name: Emily Jones

Social Security Number: 420-39-6073

Birth Date: 03/18/1992

205-317-8674 334-354-9724

Local Phone Number: 334-354-5599

Alternate Number: 215

425 N. Bar Bank,

WHITMAN HALL 513

East Date Oaks

017

Local Address: North Commons 3018

Appt.

Box Number: 532

City: Montgomery

State: AL

Zip Code: 36117

Permanent Address: 89 Carver Ave

City: Annore

State: AL

Zip Code: 36502

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

Sex: Male ☐ ☒ Female (Please Circle)

Primary Physician: _____

City: _____

Phone #: _____

Patient's Employer: _____

Work #: _____

Parent's or Spouse's Name (Circle which): Minnie L. Jones

Phone #: _____

Parent's or Spouse's Employer: William F. Green

Work #: 251-937-0881

Emergency Contact: Stephanie W.

Relationship: sister

Phone #: (251)-253-3802

How did you hear about the Clinic? (Please Circle) Friend Faculty/Staff ☒ Orientation ☐ Other _____

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.

CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Student Health Center (Nursing Care Center).

Signature X _____

Signature of patient or parent/guardian, if patient is a minor.

SERVICES CONSENT FORM

NAME: Emily Jones
DATE OF BIRTH: 03/18/92

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: Emily Jones
DATE: 10/27/10

SIGNATURE: _____
DATE: _____

SIGNATURE: Emily Jones
DATE: 02/18/11

SIGNATURE: _____
DATE: _____

SIGNATURE: Emily Jones
DATE: 9/12/14

SIGNATURE: _____
DATE: _____

SIGNATURE: Emily Jones
DATE: 9/30/14

SIGNATURE: _____
DATE: _____

SIGNATURE: Emily Jones
DATE: 2/26/15

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AUM Student Health Services

PATIENT HIPAA 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 (HIPAA). I understand that by signing this consent I authorize you 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 healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you 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 you are not required to agree to these requested restrictions. However, if you do agree, you 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 26 day of Feb. 2015.

Print Patient Name Emily Jones

Signature 

Relationship to Patient _____

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

Name: Emily Jones Date of Birth: 3 118 192

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 _____

☐ 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: 205-317-8674

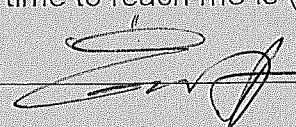
If unable to reach me:

☒ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) Any day between (time) 3:30 - 5:00 pm

Signed:  Date: 2 126 115

Patient Name Emily Anne Date of Birth 03/18/92

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.

Payment

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

07/10/2015
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient