

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 6/14/17 Are you an AUM student? YES NO Student ID # _____

Name: Zachary Sollie

Social Security Number: 424-41-2534 Birth Date 03/06/1994

Local Phone Number: (334) 707-8347 Alternate Number: ~~(334) 728-9240~~
(334) 728-9240

Local Address: 7064 Taylor Crossing Dr. Box Number Apt 6
36117

City: Montgomery State: AL Zip Code: 36104

Permanent Address: 355 Lee Rd 431

City: Opelike State: AL Zip Code: 36804

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

Sex (Please Circle): Male Female

Primary Physician: Justin Campbell City: Opelike, AL Phone #: (334) 749-3385

Patient's Employer: Phys Assist Scribes Work #: (334) 707-8347

Parent's or Spouse's Name (Circle which) Lena Sollie Phone #: (334) 728-9240

Parent's or Spouse's Employer: Morey Medical Center Work #: (334) 728-9240

Emergency Contact: Lena Sollie Relationship: Mother Phone #: (334) 728-9240

How did you hear about the Clinic? 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.

Insurance Company _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Zachary Solie Date of Birth 08/06/1994

General Consent for Treatment

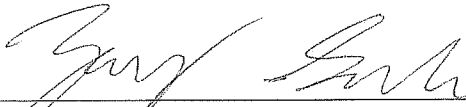
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

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 14
08, 06, 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 14 day of June 2017.

Print Patient Name Zachary Soliz

Signature [Handwritten Signature]

Relationship to Patient Patient

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

Name: Zachary Solie Date of Birth 03/06/1994

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: Parents: Lena Solie

☐ 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: (334)-707-8347

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) Sunday - Saturday between 8 am and 10 pm times.

Signed: _____

Date: 6/19/17