

Emily Shimaz

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 6/16/2017 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: EMILY SHIMAZ Preferred Name _____

Social Security Number: 419-33-9524 Birth Date 9-28-1988

Local Phone Number: 334-296-0469 Alternate Number: _____

Local Address: 144 Jamestown Loop Box Number _____

City: Millbrook State: AL Zip Code: 36054

Permanent Address: Same

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒ Transgender

Primary Physician: Dr. Wilcox City: Prattville Phone #: 334-730-0880

Patient's Employer: AUM Work #: 334-244-3892

Parent's or Spouse's Name (Circle which) Shim Shimaz Phone #: 334-354-7397

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

Emergency Contact: Shim Shimaz Relationship: Husband Phone #: 334-354-7397

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 BCBS of AL Name on Card Emily M. Shimaz

Policy Number PPA848059183 Group Number 37655

Insurance Company Address _____

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 16 day of June 2017.

Print Patient Name EMILY SHIMAZ

Signature E. Shimaz

Relationship to Patient SELF

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Emily SHIMAZ Date of Birth 09/28/1988

General Consent for Treatment

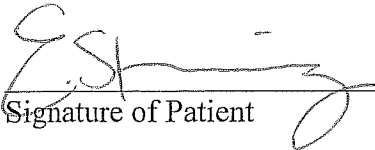
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

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

06/16/2017

Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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

Name: Emily SHIMAZ Date of Birth 6/16/2017

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: Shim Shimaz

☐ 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: (334)-2910-0409

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) Any day between _____ and _____ times.

Signed: E. Shimaz

Date: 6/16/2017