

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 6-26-17 Are you an AUM student? ☒ YES ☐ NO Student ID # S00079387

Name: Zachary Allen Bedding

Social Security Number: 418-39-6164 Birth Date: 03-02-1992

Local Phone Number: 334-322-0489 Alternate Number: _____

Local Address: 685 South Tallassee Drive Box Number: _____

City: Tallassee State: AL Zip Code: 36078

Permanent Address: Same as Above

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: Rodney Griffith Excavating Work #: 334-283-5391

Parent's or Spouse's Name (Circle which): ☒ Parent ☐ Spouse Stephanie Hornsby Phone #: 334-207-8739

Parent's or Spouse's Employer: City of Tallassee Work #: 334-283-4298

Emergency Contact: Stephanie Hornsby Relationship: Mother Phone #: 334-207-8739

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 Name on Card Zachary Bedding

Policy Number ZRH517M87670 Group Number 174551M1A3

Insurance Company Address _____

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 26th day of June 20 17.

Print Patient Name Zachary Redding

Signature Zachary Redding

Relationship to Patient _____

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

Name: Zachary Bedding Date of Birth 03/02/1992

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: (334)-322-0489

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, Any time between _____ and _____ times.

Signed: Zachary Bedding

Date: 06/26/17