

AUM STUDENT HEALTH CENTER**PATIENT INFORMATION (PLEASE PRINT)**Date: 3-16-15 Are you an AUM student? YES ☒ NO ☐ Student ID # _____Name: Sarah B. StrubySocial Security Number: 418-76-7419 Birth Date: 1-11-15Local Phone Number: 334-265-4659 Alternate Number: NALocal Address: 21 S. Maryland St. Box Number: _____City: Montgomery State: AL Zip Code: 36107Permanent Address: 2105 Capitol AveCity: Montgomery State: AL Zip Code: 36107Marital Status (Please Circle): ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____Sex (Please Circle): Male ☐ Female ☒Primary Physician: Bruce Kent City: Netumpka, AL Phone #: _____Patient's Employer: CCAD Work #: 567-5626Parent's or Spouse's Name (Circle which) NA Phone #: NAParent's or Spouse's Employer: NA Work #: NAEmergency Contact: Len Struby Relationship: Sister Phone #: 261-2414 (w)How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other employer**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 _____

Patient Bill of Rights

AUM Nursing Care Center (AUM NCC) exists primarily for the purpose of providing high quality care that meets or exceeds accepted standards for care. AUM NCC believes that each client is worthy of respect and understanding and has certain rights and responsibilities related to the care he/she receives. In accordance with this philosophy, AUM NCC wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights.

As a client of AUM NCC, you have the right to:

1. Be treated with dignity, courtesy, and respect.
2. Obtain from caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. Know the identity of all caregivers involved in their care, as well as when those involved are students or trainees.
4. Know the immediate and long-term financial implications of treatment choices, insofar as they are known.
5. Make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and AUM NCC policy and to be informed of the medical consequences of the action. In case of refusal, the patient is entitled to other appropriate care and services or to be referred to another health care facility.
6. Receive competent, individualized quality services from AUM NCC regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, or any other category protected by law.
7. Expect confidentiality of all clinical records and access to your records on request. Information will not be released to anyone without your written consent or unless required by law.
8. Have family or guardian exercise these rights on your behalf if you are unable to do so yourself.
9. Voice grievances about care which is or is not provided, recommend policy/service changes, and make complaints without fear of reprisal or unreasonable interruption of care.

I also understand I have a responsibility to:

1. Provide accurate and complete information to AUM NCC regarding medical history and current condition and medications, and to promptly inform AUM NCC of any changes in this information.
2. Agree to accept all caregivers regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law.
3. Participate in planning, evaluation and revising my plan of care to the degree that I am able to do so and to take responsibility for my actions and for the impact that those actions have on my health and recovery.
4. Adhere to the plan of care which I have participated in developing.
5. Treat AUM NCC staff with respect, courtesy, and consideration.

I have read and understand the above Patient Bill of Rights and agree to the contents thereof.

Patient Signature: _____

Sarah B. Shady

Date: _____

3-16-15

SERVICES CONSENT FORM

NAME: _____

DATE OF BIRTH: _____

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: *Samuel B. Shubert*

DATE: 3-19-15

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: _____

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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 16th day of March 2015.

Print Patient Name Sarah B. Struby

Signature Sarah B. Struby

Relationship to Patient self

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

Name: Sarah B. Struby Date of Birth: 1.11.52

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 CCAD / Glenwood

☐ 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: 334-265-4659

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) varies between (time) varies

Signed: Sarah B. Struby Date: 3/16/15

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 8-15-17 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Sarah B. Struby

Social Security Number: 418-76-7419 Birth Date: 1-11-52

Local Phone Number: 334-265-4659 Alternate Number: none

Local Address: 2105 Capitol Ave Box Number _____

City: Mtgomery State: AL Zip Code: 36107

Permanent Address: same

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Dr. Bruce Kent City: Wetumpka Phone #: 2

Patient's Employer: Glenwood (Birmingham, AL) Work #: 2

Parent's or Spouse's Name (Circle which) none Phone #: NA

Parent's or Spouse's Employer: none Work #: NA

Emergency Contact: Dr. Lou Struby Relationship: Sister Phone #: 334-264-2414

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

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 _____

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- 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 15th day of August 2017.

Print Patient Name Sarah B. Shuby

Signature Sarah B. Shuby

Relationship to Patient Self

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

Name: Sarah B. Struby Date of Birth 1/11/52

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: sister - Dr. HZ Struby

☐ 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: (____)-____-____

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 between _____ and _____ times.

Signed: Sarah B. Struby

Date: 8/15/17

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Sarah B. Shuby Date of Birth 8/15/17

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.

Sarah B. Shuby
Signature of Patient

8/15/17
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient