

AUM NURSING CARE CENTER

PATIENT INFORMATION (Print Please)

Date: 2/24/06

Name: Deric Sallas

Student ID #: _____ Birth Date: 10/21/88

Local Phone Number: (334) 395-6907 Alternate Number: (334) 394-1370

Local Address: 307 Bridlebrook Blvd. Box Number: _____

City: Montgomery State: AL Zip Code: 36064

Permanent Address: Same

City: Montgomery State: AL Zip Code: 36064

Marital Status: Single ☒ Married ☐ Divorced ☐ Widowed ☐ Other _____

Sex: Male ☒ Female ☐

Primary Physician: Dr. Allen White City: Montgomery Phone #: 277-5959

Patient's Employer: Student Work #: _____

Parent's or Spouse's Name: (indicate which one) Polly Sallas (Mother) Phone #: 334-1370

Parent's or Spouse's Employer: Grace Pointe Church Work #: 271-2525

Emergency Contact: Arlene Morris Relation friend Phone #: 277-5885

How did you hear about our clinic? Friend ☐ Faculty Staff ☒ Orientation ☐ Other: _____

*deric's #
540-7509*

INSURANCE INFORMATION

Do you have health insurance? Yes ☒ No ☐ If yes, please complete the following information.

Name of insured: Charles G. Sallas Relationship to patient: Father

Insurance Company: Blue Cross Blue Shield of Alabama

Policy Number: XAA800014145 Group Number: 29404

Insurance Company Address: 450 Riverchase Parkway East

City: Birmingham State: AL Zip Code: 35244-2858

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 Nursing Care Center.

Signature X: _____

Polly Sallas

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

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: David S. S. S.

DATE: 4/13/2010

SIGNATURE: _____

DATE: _____

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AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Doriz Salas

Date of Birth 10 / 21 / 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.

Doriz Salas
Signature of Patient

1 / 13 / 2016
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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 HIPAA 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 13 day of January 2016.

Print Patient Name Deric Sallas

Signature Deric Sallas

Relationship to Patient _____

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

Name: Doriz Salas Date of Birth: 10 / 21 / 1988

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 _____

☐ 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: 334-590-7509

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) before 5

Signed: Do See Date: 1 / 13 / 2016