

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 7/27/2017 Are you an AUM student? YES NO Student ID # 00050889 ~~00050889~~

Name: Dore Salas

Social Security Number: 417-37-4500 Birth Date 10/21/1988

Local Phone Number: 334-590-7509 Alternate Number:

Local Address: 307 Bridle Brook Blvd Box Number

City: Dike Road State: AL Zip Code: 36064

Permanent Address:

City: State: Zip Code:

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

Sex (Please Circle): Male Female

Primary Physician: Strickland City: Montgomery Phone #:

Patient's Employer: Fitzgerald Museum/Auburn Montgomery Work #:

Parent's or Spouse's Name (Circle which) Polly Salas Phone #: 334-354-1370

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

Emergency Contact: Heather Adams Relationship: Dating Phone #:

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 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.

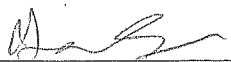
I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change 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 27th day of July 20 17.

Print Patient Name Doniz Salas

Signature 

Relationship to Patient

AUM Student Health Services

Medical Information Release Form

(HIPPA Release Form)

Name: Donz Sallas Date of Birth 10/21/1982

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: Dolly and Greg Sallas

[] 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: (534)-590-7509

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) Weekdays between 8 and 5 times.

Signed: Donz Sallas

Date: 7/27/2017

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Derric Sallas Date of Birth 10 / 21 / 1988

General Consent for Treatment

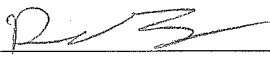
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

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.


Signature of Patient

7 / 27 / 2017
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient
