

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 11-12-13 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: Joyelyn Bozeman

Social Security Number: 416-17-2040 Birth Date 4-24-69

Local Phone Number: (334) 318-9775 Alternate Number: _____

Local Address: _____ Box Number 240782

City: Montgomery State: AL Zip Code: 36124

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male Female

Primary Physician: Dr. Garraud City: Montgomery Phone #: _____

Patient's Employer: AUM Work #: _____

Parent's or Spouse's Name (Circle which) N | A Phone #: _____

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

Emergency Contact: Catherine Williams Relationship: Auntie Phone #: (334) 284-0297

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 CENTER
CONSENT FOR SERVICES FORM

Patient Name Joyelyn Bozeman

Date of Birth 7/24/69

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.

Joyelyn Bozeman
Signature of Patient

11/17/2014
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

DATE 3/28/97

AUM NURSING CARE CENTER

PATIENT INFORMATION

(PLEASE PRINT)

NAME Joycelyn Bozeman SS# 416-12-2040 BIRTHDATE 7-24-69 HOME PHONE 288-2118
ADDRESS 4725 Coventry Rd CITY Norhtg STATE Ala ZIP 36116
CIRCLE ONE: ☒ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED SEX: M ☐ F ☒
PRIMARY PHYSICIAN _____
OFFICE LOCATION _____ PHONE # _____
PATIENT'S OR PARENT'S EMPLOYER Aum WORK PHONE 244-3685
SPOUSE OR PARENT'S NAME Marilyn Griffin EMPLOYER Housing Authority WORK# 206-7182
IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE N/A CITY _____ STATE _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY Marilyn Griffin RELATION: Mother PHONE 288-0162
HOW DID YOU HEAR ABOUT US? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT Same as above RELATION TO PATIENT
ADDRESS _____ HOME PHONE _____
BIRTHDATE _____ WORK PHONE _____
EMPLOYER _____
DRIVER'S LICENSE # _____

INSURANCE INFORMATION

NAME OF INSURED Blue Cross Blue Shield RELATION TO PATIENT
INSURANCE CO. _____ GROUP # _____ UNION OR LOCAL # _____
INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____
DEDUCTIBLE AMOUNT _____ HOW MUCH HAS BEEN USED? _____ MAX. ANNUAL BENEFIT? _____

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 x

Joycelyn Bozeman
SIGNATURE OF PATIENT OR PARENT, IF MINOR

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 10 day of 13 2014.

Print Patient Name Joyce Lynn Bozeman

Signature Joyce Lynn Bozeman

Relationship to Patient _____

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

Name: Joyelyn Bozeman Date of Birth: 4, 24, 1969

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 Catherine Williams (Auntie)

☐ 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: 334-318-9775

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) anytime between (time) _____

Signed: Joyelyn Bozeman Date: 10, 9, 2014

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: Joyelyn Bozeman
DATE: 10-29-98

SIGNATURE: _____
DATE: _____

SIGNATURE: Joyelyn Bozeman
DATE: 12-10-01

SIGNATURE: _____
DATE: _____

SIGNATURE: Joyelyn Bozeman
DATE: 12-2-03

SIGNATURE: _____
DATE: _____

SIGNATURE: Joyelyn Bozeman
DATE: 10-1-04

SIGNATURE: _____
DATE: _____

SIGNATURE: Joyelyn Bozeman
DATE: 3-23-04

SIGNATURE: _____
DATE: _____

2 SIGNATURE: Joyelyn Bozeman
DATE: 4-30-09

SIGNATURE: _____
DATE: _____

SIGNATURE: Joyelyn Bozeman
DATE: 2/24/10

SIGNATURE: _____
DATE: _____

SIGNATURE: Joyelyn Bozeman
DATE: 10-9-2014

SIGNATURE: _____
DATE: _____

SIGNATURE: Joyelyn Bozeman
DATE: 10-4-2014

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

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DATE: _____

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DATE: _____

SIGNATURE: _____
DATE: _____



BlueCross BlueShield
of Alabama

BLUE CROSS
**PREFERRED
CARE**

Subscriber Name
JOYCELYN R BOZEMAN
Contract Number
PPA822631310

AUBURN UNIVERSITY

Group Number 37655
Effective Date 04-20-2007
Rx BIN Number 004915

HEALTH

PAC



Rx