

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 10-22-15 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: Paige Hines

Social Security Number: 422-27-7173 Birth Date 3-5-77

Local Phone Number: 334-244-3201 Alternate Number: 334-313-1579

Local Address: 103 Pauline Circle Box Number _____

City: Wetumpka State: AL Zip Code: 36092

Permanent Address: Same

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Amanda Wilcox City: Prattville Phone #: _____

Patient's Employer: AUM Work #: _____

Parent's or Spouse's Name (Circle which) Lee Hines Phone #: 391-9041

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

Emergency Contact: Lee Hines Relationship: Spouse Phone #: 391-9041

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 Paige B Hines

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Paige Hines Date of Birth 3/5/77

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.

P. Hines
Signature of Patient

6/22/15
Date of Signature

Signature of Legal Representative (if patient unable to sign)

patient
Relationship to Patient

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

Name: Paige Hines Date of Birth: 3/5/77

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 Lee Hines

☐ 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: 313-1579

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) _____ between (time) _____

Signed: _____ Date: ____/____/____