

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 8/23/17 Are you an AUM student? ☒ YES ☐ NO Student ID # 00147733

Name: Kiara Fitzpatrick

Social Security Number: 424-37-5626 Birth Date 10/30/91

Local Phone Number: 334-781-8643 Alternate Number: N/A

Local Address: 7400 East Dirac Ln 127 Taylor Center Aum Box Number 919

City: Montgomery State: AL Zip Code: 36124

Permanent Address: 1177 Red Oak Circle

City: Fairfield State: AL Zip Code: 35064

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: N/A City: _____ Phone #: _____

Patient's Employer: N/A Work #: _____

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

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

Emergency Contact: _____ Relationship: _____ 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.

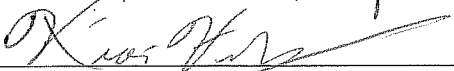
I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change 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 23 day of August 2017.

Print Patient Name Kiara Fitzpatrick

Signature 

Relationship to Patient _____

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

Name: Kiara Fitzpatrick Date of Birth 10/30/91

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: N/A

[] Child(ren): N/A

[] Other: Only me.

[x] 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 [x] my cell number: (834)-781-8643

If unable to reach me:

[] you may leave me a detailed message

[x] please leave a message asking me to return your call

[] other: _____

The best time to reach me is (day or days) Friday Anytime between Tues-Thurs 2:30pm-5pm and Tues-Thurs 2:30pm-5pm times.

Signed: Kiara Fitzpatrick

Date: 8/23/17

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Kiara Fitzpatrick Date of Birth 10/30/91

General Consent for Treatment

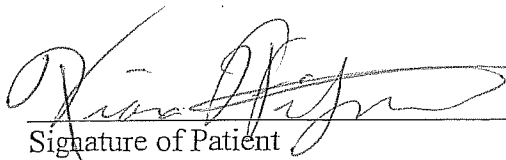
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

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

N/A
Signature of Legal Representative (if patient unable to sign)

8/23/91
Date of Signature

N/A
Relationship to Patient