

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT)

Date: 8/8/2017 Are you an AUM student? ☒ YES ☐ NO Student ID # 500345225

Name: Sungun Jung

Social Security Number: \_\_\_\_\_ Birth Date 09/15/1987

Local Phone Number: 519-331-5623 Alternate Number: \_\_\_\_\_

Local Address: 800 Josephine Lane, Apt 8201 Box Number \_\_\_\_\_

City: Montgomery State: AL Zip Code: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ 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 \_\_\_\_\_

Negative Imm TB Results

## 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 8<sup>th</sup> day of AUG 2017.

Print Patient Name Gangan Jung

Signature [Signature]

Relationship to Patient Self