

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 8/15/17 Are you an AUM student? ☒ YES ☐ NO Student ID # 500150010

Name: ALEXANDRA WALTERS

Social Security Number: 420 46 6861 Birth Date: 4/10/95

Local Phone Number: 334-590-9135 Alternate Number: 334-590-4753

Local Address: 2820 ASHLEY AVENUE Box Number: _____

City: MONTGOMERY State: AL Zip Code: 36109

Permanent Address: 2820 ASHLEY AVENUE

City: MONTGOMERY State: AL Zip Code: 36109

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) ☒ JUTIA WALTERS Phone #: 334-590-4753

Parent's or Spouse's Employer: DISA Work #: 334-416-2954

Emergency Contact: JUTIA Relationship: MOM Phone #: 334-590-54753

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 STANTON E WALTERS

Policy Number R59651365 Group Number 65006500

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 15 day of AUGUST 20 17.

Print Patient Name ALEXANDRA WALTERS

Signature Alexandra Walters

Relationship to Patient _____

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

Name: ALEXANDRA WALTERS Date of Birth 4/10/95

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:

- ☐ ^{MOM} Spouse: JUTTA WALTERS
☐ ^{PAD} Child(ren): STAN WALTERS
☐ 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: (334)-590-9135

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) _____ between
_____ and _____ times.

Signed: Alexandra Walters

Date: 8/15/17

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name ALEXANDRA WALTERS Date of Birth 11/10/95

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.

Alexandra Walters
Signature of Patient

8/15/17
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient