

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 11/19/12 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: Shae Robinson (Sekertha)

Social Security Number: 424061722 Birth Date: 12/21/1977

Local Phone Number: 334-590-7134 Alternate Number: 334-3561453

Local Address: 31 Eagerton Rd Box Number _____

City: Mont State: AL Zip Code: 36116

Permanent Address: same

City: _____ State: _____ Zip Code: _____

Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other _____

Sex: Male ☐ Female ☒ (Please Circle)

Primary Physician: Dr. Glynn City: mont Phone #: _____

Patient's Employer: Aum Work #: _____

Parent's or Spouse's Name (Circle which) Roderick Robinson Phone #: 590-7131

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

Emergency Contact: Bobbie Melt Relationship: mom Phone #: 538-3007

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.

CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Student Health Center (Nursing Care Center).

Signature X Shae Robinson
Signature of patient or parent/guardian, if patient is a minor.

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Seketha (Shae) Robinson Date of Birth 12/21/77

General Consent for Treatment

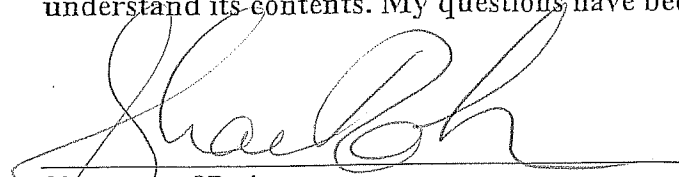
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

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.


Signature of Patient

10/16/15
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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 HIPAA 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 16 day of October 2015.

Print Patient Name

Shae Robinson

Signature

Shae Robinson

Relationship to Patient

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

Name: Sekenta (Shae) Robinson Date of Birth: 12/21/77

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 Roderick Robinson

☐ 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: _____

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) open between (time) open

Signed: Shae Robinson Date: 10/16/15