

AUM STUDENT HEALTH CENTER

Dep A

PATIENT INFORMATION (PLEASE PRINT)

Date: 10-1-17 Are you an AUM student? YES/NO NO Student ID # _____

Name: Cassidy Baillie

Social Security Number: 532353231 Birth Date: 10-05-1995

Local Phone Number: (360) 909-1700 Alternate Number: N/A

Local Address: 2431 Hermitage Dr Box Number _____

City: Montgomery State: AL Zip Code: 36111

Permanent Address: 19401 SE 31st Dr

City: Camas State: WA Zip Code: 98607

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

Sex (Please Circle): Male Female Female

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

Patient's Employer: CCT volleyball Work #: _____

Parent's or Spouse's Name (Circle which) Wendi Hamann Phone #: (360) 905-2130 24

Parent's or Spouse's Employer: Advanced Accounting Work #: 11

Emergency Contact: Reed Hamann Relationship: Dad Phone #: (360) 909-8325

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 Regence Bluecross Name on Card Reed M. Hamann

Policy Number BIK 993023988 Group Number 99903010

Insurance Company Address N/A

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name Cassidy Bailie

Date of Birth 10/09/1995

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.

Cassidy Bailie
Signature of Patient

10/1/17
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 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 1st day of June 2017.

Print Patient Name Cassidy Baillie

Signature Cassidy Baillie

Relationship to Patient _____

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

Name: Cassidy Baillie Date of Birth: 10/06/95

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:

☐ Spouse _____

☐ 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: (360) 909-1766

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) anytime between (time) _____

Signed: Cassidy Baillie Date: 11/1/17