



**AUBURN UNIVERSITY
AT MONTGOMERY**

STUDENT HEALTH SERVICES

**Patient Information Update Form
(Please Print Legibly)**

Date: 03/04/2020 Are you an AUM Student? Yes ☐ No ☒ Student Number:

Name: Kelly Cox Preferred: Birthdate: 01/16/1987

Phone Number: 334-328-7605 Email: kcox2@aum.edu

Local Mailing Address: 330 Bowling Green Dr Box or APT#:

City: Montgomery State: AL Zip Code: 36109

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

Primary Physician: Harold Cox City: Montgomery Phone #:

Emergency Contact: Betty Cox Relationship: mother Phone#: 334-328-7604

Insurance Information

Do you have health insurance? Yes ☒ No ☐
If Yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: BCBS Name of Policy Holder: Kelly Cox

Policy or Contract Number: QAU837081071 Group Number: 37655

Insurance Company's Address:

Medical History

Do you have any new allergies, medical conditions, or procedures: (Include hospitalization, illnesses, and surgeries)
nothing new

Are you taking any medications regularly at the present time (including allergy injections, antidepressants, contraceptives, over-the-counter drugs, etc.)? Yes ☒ No ☐
If yes, please list

Preferred Pharmacy and Phone number:

AUM Student Health Services

Medical Information Release

Form (HIPAA Release Form)

01/16/1987

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: Mother - Betty Cox

☐ 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) - 328 - 7605

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: [SIGN HERE] 

Date: 03/04/2020

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: KELLY COX Date of Birth: 01/18/1987
Day Month Year

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 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.

[SIGN HERE] Kelly Cox

Signature of Patient

Signature of Legal Representative (if patient is unable to sign)

03/04/2020
03 / 04 / 2020
Day Month Year

Date of Signature

Relationship to Patient

See Back of Form

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 involve 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 with 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 day of 20
(day) (month) (last two digits of the year)

Print Patient's Name:

Signature:

Relationship to Patient (if you are the patient, write "self"):