

# AUM STUDENT HEALTH CENTER - EMPLOYEES

## PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 6/22/2018 Are you an AUM Student? ☐ Yes ☒ No S-Number: \_\_\_\_\_

Name: Kelly Cox Birthdate: 1/16/1987

Main Phone Number: 244-3641 Alternate Phone Number: 328-7605

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

City: Montgomery State: AL Zip Code: 36109

Permanent/Home Address: — Box or APT #: —

City: — State: — Zip Code: —

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

Sex (Please Circle): Male (Female) Gender: Male (Female)

Primary Physician: Dr. Harold Cox City: Montgomery Phone #: \_\_\_\_\_

Patient's Employer: AUM Work Phone #: 244-3641

(Parent's) or Spouse's Name (Circle which): Betty Cox Phone #: 328-7604

Parent's or Spouse's Employer: n/a Phone #: —

Emergency Contact: Betty Cox Relationship: Mother Phone #: 328-7604

How did you hear about the clinic (Circle which): Friend (Faculty/Staff) Orientation Other: \_\_\_\_\_

## 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: BC/BS of AL Name on Card: Kelly Cox

Policy or Contract Number: QAU 837081071 Group Number: 37655

Insurance Company's Address: \_\_\_\_\_

# AUM STUDENT HEALTH CENTER

## CONSENT FOR SERVICES FORM

Patient Name: Kelly Cox Date of Birth: 01 / 16 / 87  
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.

Kelly Cox  
Signature of Patient

6 / 22 / 18  
Day Month Year  
Date of Signature

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

\_\_\_\_\_  
Relationship to Patient

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

Name: Kelly Cox Date of Birth    /   /   

**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: <sup>334</sup>~~(813)~~ - 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) M-F between 8:00 and 5:00 pm times.

Signed: Kelly L Cox

Date: 6/22/18

# AUM Student Health Services

## PATIENT HIPPAA 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 (HIPPA). 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 HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. 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 22 day of June 2018.  
(day) (month) (last two digits of the year)

Print Patient's Name: Kelly Cox

Signature: Kelly L Cox

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