

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT)

Date: 10/24/17 Are you an AUM student? YES ☐ NO ☒ Student ID # \_\_\_\_\_

Name: Jeanine Boddie Lawan

Social Security Number: 073603679 Birth Date: 11-18-65

Local Phone Number: 334/3126954 Alternate Number: 334/2443639

Local Address: 4285 Shamrock Ln Box Number \_\_\_\_\_

City: Mt State: AL Zip Code: 36106

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Leon Davis City: Mt Phone #: \_\_\_\_\_

Patient's Employer: Aum Work #: 334 244-3639

Parent's or Spouse's Name (Circle which) \_\_\_\_\_ Phone #: \_\_\_\_\_

Parent's or Spouse's Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

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 \_\_\_\_\_ Name on Card \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

AUM STUDENT HEALTH CENTER  
CONSENT FOR SERVICES FORM

Patient Name Jeannine Boldi Lark Date of Birth 11/1/86

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.

Jeannine Boldi Lark  
Signature of Patient

10/24/17  
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 24 day of October 2017.

Print Patient Name Jeanine Boddie Park

Signature Jeanine Boddie Park

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