

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 10/18/13 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Lori DuVal Rogers

Social Security Number: 265-96-1488 Birth Date: 03-14-64

Local Phone Number: 334 300-4487 Alternate Number: 334 281-7666

Local Address: 44 N. Onyx Ct. Box Number: _____

City: Pike Rd State: Al Zip Code: 36064

Permanent Address: Same as above

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Dr. Eric Graves City: Montgomery Phone #: 396-9100

Patient's Employer: Dr. Timothy Morrow City: Montgomery Work #: 281-7666 296-6986

Parent's or Spouse's Name (Circle which) Douglas Rogers Phone #: 334 300-4461

Parent's or Spouse's Employer: Al Baptist Convention Work #: 288-2460

Emergency Contact: Doug Rogers Relationship: Spouse Phone #: _____

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other former student

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 Lori D. Rogers Date of Birth 3, 14, 64

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.

Lori D. Rogers
Signature of Patient

10, 21, 15
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

AUM NURSING CARE CENTER

PATIENT INFORMATION (Print Please)

Date: 7-23-02

Name: Lori Rogers

Student ID #: 265-96-1488

Birth Date: 03-14-64

Local Phone Number: 274-1348

Alternate Number: 300-4487

Local Address: 140 Longwood Trail

Box Number: _____

City: Pike Rd

State: AL

Zip Code: 36064

Permanent Address: (Same)

City: _____ State: _____ Zip Code: _____

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

Sex: Male ☐ Female ☒

Primary Physician: Eric Graves

City: Mont.

Phone #: 396-9100

Patient's Employer: Aum Student

Work #: _____

Parent's or Spouse's Name: (indicate which one) Doug Rogers

Phone #: 7

Parent's or Spouse's Employer: AL Baptist Convention

Work #: 288-2460

Emergency Contact: Doug Rogers

Relation Spouse

Phone #: _____

How did you hear about our clinic? Friend ☐ Faculty Staff ☐ Orientation ☐ Other: _____

INSURANCE INFORMATION

Do you have health insurance? Yes ☒ No ☐ If yes, please complete the following information.

Name of insured: Doug Rogers

Relationship to patient: Spouse

Insurance Company: BGBS

Policy Number: _____

Group Number: _____

Insurance Company Address: _____

Riverchase Pkway

City: Birmingham

State: AL

Zip Code: _____

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 Nursing Care Center.

Signature X: _____

Signature of patient or parent/guardian, if patient is a minor

SERVICES CONSENT FORM

NAME: Lori Rogers
DATE OF BIRTH: 03-14-64

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: Lori Rogers
DATE: 7-26-02

SIGNATURE: Lori Rogers
DATE: 03-14-10

SIGNATURE: Lori Rogers
DATE: 03-17-14
10/29/14

SIGNATURE: _____
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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 27 day of October 2014.

Print Patient Name Lori DuVal Rogers

Signature Lori Rogers

Relationship to Patient self

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

Name: Lori DuVal Rogers Date of Birth: 3, 14, 60

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 Douglas W. Rogers
☒ Child(ren) Bethany J. Rogers, Emilee C. Rogers
☒ Other Dr. Eric Graves

☐ 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: 300-4487

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) _____ between (time) _____

Signed: Lori Rogers Date: 10, 27, 14