

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: Nov. 1, 2017 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Frank Caswell Williams

Social Security Number: 253-92-4560 Birth Date: August 15, 1956

Local Phone Number: 334-567-8183 Alternate Number: 334-244-3627

Local Address: 185 Greer Rd. Box Number _____

City: Wetumpka State: AL Zip Code: 36092

Permanent Address: Same

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: Lauren Barnes City: Montgomery Phone #: 334-279-9211

Patient's Employer: AUM Work #: 334-244-3627

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

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Roxanne Brown Relationship: Sister Phone #: 229-460-5375

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: BCBS Name on Card: Frank C. Williams

Policy Number: XAC 809 Group Number: 37655

Insurance Company Address: Birmingham, AL

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 1 day of November 20 17.

Print Patient Name Frank C. Williams

Signature Frank C. Williams

Relationship to Patient Self



BlueCross BlueShield
of Alabama

BLUE CROSS
**PREFERRED
CARE**

Subscriber Name
FRANK C WILLIAMS
Contract Number
XAC809180089

AUBURN UNIVERSITY

Group Number 37655
Effective Date 01-01-2016
Rx BIN Number 004915

HEALTH

PAC





www.AlabamaBlue.com

Providers file claims and direct questions about claim payments to the local Blue Cross and/or Blue Shield Plan.

Blue Cross and Blue Shield of Alabama provides administrative services only and does not assume any financial risk for claims.

Member Customer Service: 1 800 633-8052
PPO Provider Locator: 1 800 810-2583
Preadmission Certification: 1 800 748-2342
Provider Benefits/Eligibility: 1 800 517-5425
Pharmacist: 1 800 216-9920

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
An Independent Licensee of the
Blue Cross and Blue Shield Association.

IDC003-015

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Frank C. Williams Date of Birth 8/15/56

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.

Frank C. Williams
Signature of Patient

11/1/17
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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

Name: Frank C. Williams Date of Birth 8/15/56

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: Sister - Roxanne Brown

☐ 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)-567 - 8183
334 - 328 - 2805

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) Any time between _____ and _____ times.

Signed: Frank C. Williams

Date: 11/1/17