

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 3-10-15 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Michael Lewis

Social Security Number: 417-11-9253 Birth Date 9-5-1962

Local Phone Number: 334-593-7998 Alternate Number: 233-4740

Local Address: 820 Millard Fuller Drive Box Number _____

City: Montgomery State: Alabama Zip Code: 36110

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Patricia Elliot City: Montgomery Phone #: _____

Patient's Employer: Aum Police Work #: 204-3424

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

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

Emergency Contact: Mary Harris Relationship: Sister Phone #: 354-3206

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 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 3 day of 10 2015.

Print Patient Name

Maheell Lewis

Signature

Maheell Lewis

Relationship to Patient

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

Name: Michelle Lewis Date of Birth: 9 / 5 / 1962

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 _____

☒ 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: 233-4746

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: Michelle Lewis Date: ____ / ____ / ____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name _____

Date of Birth ____/____/____

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.



Signature of Patient

7.1.15
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

AUM NURSING CARE CENTER

PATIENT INFORMATION (Print Please)

Date: 11-28-06
Name: Maebell Lewis
Student ID #: 271 2001 Birth Date: 9-5-62
Local Phone Number: ~~277-1723~~ Alternate Number: 244-3763
Local Address: 820 Milford fuller Dr Box Number: _____
City: Montgomery State: Alabama Zip Code: 36110
Permanent Address: Same as above
City: _____ State: _____ Zip Code: _____
Marital Status: Single ☒ Married ☐ Divorced ☐ Widowed ☐ Other _____
Sex: Male ☐ Female ☒
Primary Physician: _____ City: _____ Phone #: _____
Patient's Employer: _____ Work #: _____
Parent's or Spouse's Name: (indicate which one) _____ Phone #: _____
Parent's or Spouse's Employer: _____ Work #: _____
Emergency Contact: Mary Folks Relation Aunt Phone #: 269-1642
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: B/c B/s Maebell Lewis Relationship to patient: _____
Insurance Company: B/c B/s
Policy Number: _____ Group Number: 37655
Insurance Company Address: _____
City: _____ State: _____ 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: _____

DATE OF BIRTH: _____

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: Michelle Leri

DATE: 06-17-2008

SIGNATURE: Michelle Leri

DATE: _____

SIGNATURE: _____

DATE: _____

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