

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 2-9-15 Are you an AUM student? YES NO Student ID # _____

Name: Amanda Moss

Social Security Number: 418-15-9120 Birth Date: 1-26-79

Local Phone Number: 590-3132 Alternate Number: 244-3382

Local Address: 7048A Taylor Crossing Dr. Box Number _____

City: Montgomery State: AL Zip Code: 36117

Permanent Address: SAME

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male Female

Primary Physician: Dr. Hill-Graham City: Montgomery Phone #: 244-4322

Patient's Employer: AUM Work #: 244-3382

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

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

Emergency Contact: Rosie Randolph Relationship: mother Phone #: 251-227-5266

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 9 day of February 2015.

Print Patient Name Amanda Moss

Signature Amanda Moss

Relationship to Patient self

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

Name: Amanda Moss Date of Birth: 01 / 26 / 79

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: 540-3132

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: Amanda Moss Date: 2 / 9 / 15

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 4-17-12 Are you an AUM student? YES ☐ NO ☒

Name: Amanda Moss

Social Security Number: 418-15-9120 Birth Date: 1-26-79

Local Phone Number: 590-332 Alternate Number: 244-3382

Local Address: 131 Live Oak Dr. Box Number: _____

City: Prattville State: AL Zip Code: 36067

Permanent Address: Same

City: _____ State: _____ Zip Code: _____

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

Sex: Male ☐ Female ☒ (Please Circle)

Primary Physician: Dr. Carter City: Andalusville Phone #: 361-9979

Patient's Employer: AUM Work #: 244-3382

Parent's or Spouse's Name (Circle which): James Moss Phone #: 467-8598

Parent's or Spouse's Employer: Self-employed Work #: _____

Emergency Contact: James Moss Relationship: Spouse Phone #: 467-8598

How did you hear about the Clinic? (Please Circle) 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.

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 Student Health Center (Nursing Care Center).

Signature X Amanda Moss

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

SERVICES CONSENT FORM

NAME: Amanda Moss
DATE OF BIRTH: 1-26-19

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: Amanda Moss
DATE: 4-17-12

SIGNATURE: _____
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SIGNATURE: Amanda Moss
DATE: 8-30-12

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SIGNATURE: Amanda Moss
DATE: 5-4-15

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