

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 10/4/11 Are you an AUM-student? YES Staff NO (NO)

Name: Ana R. Eshee

Social Security Number: 244-45-9701 Birth Date: 2/11/69

Local Phone Number: 277-9040 Alternate Number: 354-7929

Local Address: 1472 Worthing Rd Box Number: _____

City: Mont State: AL Zip Code: 360117

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. Freeman City: Prattville Phone #: ()

Patient's Employer: Aum Work #: 244-3733

Parent's or Spouse's Name (Circle which): James Eshee Phone #: 221-6378

Parent's or Spouse's Employer: Self Employed/USPS Work #: " "

Emergency Contact: Spouse Relationship: _____ Phone #: _____

How did you hear about the Clinic? (Please Circle) Friend Faculty/Staff Orientation Other _____

INSURANCE INFORMATION

Do you have health insurance? YES (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 _____

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

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Ana Fiashee Date of Birth 02/11/69

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.

Ana Fiashee
Signature of Patient

01, 20, 16
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 9 day of 20 20 16.

Print Patient Name Aria Foster

Signature Aria Foster

Relationship to Patient same

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

Name: Ana Foshell Date of Birth: 02, 11, 69

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: 354-7929

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) Anytime between (time) _____

Signed: Ana Foshell Date: 01, 20, 16