

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 01/16/18 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Melissa Monroe

Social Security Number: 416-35-2672 Birth Date 12/04/1989

Local Phone Number: 334-707-3141 Alternate Number: 334-734-4654

Local Address: 1330 Shug Jordan Pkwy Box Number Apt H3

City: Auburn State: AL Zip Code: 36832

Permanent Address: "same"

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): ☐ Male ☒ Female

Primary Physician: Brian Wood City: Auburn Phone #: 334-821-2708

Patient's Employer: none Work #: _____

Parent's or Spouse's Name (Circle which) none Phone #: _____

Parent's or Spouse's Employer: none Work #: _____

Emergency Contact: Cynthia Monroe Relationship: Mom Phone #: 334-703-7935

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 Medicaid Name on Card Melissa Monroe

Policy Number _____ Group Number 5300006110032

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 HIPAA 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 16th day of January 20 18.

Print Patient Name Melissa Monroe

Signature Melissa Monroe

Relationship to Patient self

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

Name: Melissa Monroe Date of Birth 12/04/1989

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): Landen Pitts, Son

☒ Other: Cynthia Monroe, Mother

☐ 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)-707-3141

If unable to reach me:

☐ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: mmonroe145691@tray.edu /melissam33431@gmail.com

The best time to reach me is (day or days) _____ between
2:30 pm and 5 pm times. (Evening)

Signed: Melissa Monroe

Date: 01/18/18

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Melissa Monroe Date of Birth 12 / 4 / 1989

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.

Melissa Monroe

Signature of Patient

01 / 16 / 2018

Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient