

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT)

Date: 1/16/18 Are you an AUM student? YES ☒ NO ☐ Student ID # \_\_\_\_\_

Name: Rachel Riccelli

Social Security Number: 025-52-0925 Birth Date: 10/12/1958

Local Phone Number: 334-593-0870 Alternate Number: 334-546-2493

Local Address: 3331 Arborfield Rd Box Number \_\_\_\_\_

City: Montgomery State: AL Zip Code: 36109

Permanent Address: same as above

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: Shelly Byrd City: Montgomery Phone #: 293-6000

Patient's Employer: Brantwood Children's Home Work #: 205-0784

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

Parent's or Spouse's Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency Contact: Mary Raphael Relationship: Sister Phone #: 270-3358

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: N/A 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 16 day of JANUARY 20 18.

Print Patient Name Rachel Bicecci

Signature Rachel Bicecci

Relationship to Patient —

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

Name: Rachel Riccelli Date of Birth 1/16/18

**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: Boys and Girls Club

☐ 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)-543-0572

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) evenings between  
8 and 9 times.

Signed: Rachel Riccelli

Date: 1/16/2018

**AUM STUDENT HEALTH CENTER**  
**CONSENT FOR SERVICES FORM**

Patient Name Rachel Riccell Date of Birth 1/16/18

**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.**

Rachel Riccell  
Signature of Patient

1/16/18  
Date of Signature

\_\_\_\_\_  
Signature of Legal Representative (if patient unable to sign)

\_\_\_\_\_  
Relationship to Patient