

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 01-25-18 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Cartney Bagents Cochran

Social Security Number: 420-24-0488 Birth Date 04-24-87

Local Phone Number: 334-224-4207 Alternate Number: _____

Local Address: 529 Mittyhene Drive 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: Jenna Peppers City: Montgomery Phone #: _____

Patient's Employer: AUM School of Nursing Work #: 244-3658

Parent's or Spouse's Name (Circle which): Joshua Cochran Phone #: 334-531-9376
State of AL - 19th Judicial

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

Emergency Contact: Joshua Cochran Relationship: Spouse Phone #: 334-531-9376

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 BCBS Name on Card Cartney Cochran

Policy Number PPA825030859 Group Number _____

Insurance Company Address 450 Riverchase Pkwy East
Birmingham, AL 35244

Scan Back

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 11-17-16 Are you an AUM student? YES ☒ NO ☐ Student ID # _____
Employee

Name: Courtney Cochran

Social Security Number: 470-27-0088 Birth Date: 04-24-1987

Local Phone Number: 334-224-4207 Alternate Number: _____

Local Address: 529 Mitylene Drive Box Number _____

City: Montgomery State: AL Zip Code: 36117

Permanent Address: 529 Mitylene Drive

City: Montgomery State: AL Zip Code: 36117

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: NA City: _____ Phone #: _____

Patient's Employer: AUM School of Nursing Work #: _____

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

Parent's or Spouse's Employer: State of AL - Autauga County DAs Office Work #: _____

Emergency Contact: Joshua Cochran Relationship: Spouse Phone #: 334-531-9376

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: BCBS Name on Card: Joshua D. Cochran

Policy Number: EIB901442084 Group Number: 13000

Insurance Company Address: 450 Riverchase Parkway East

Birmingham, AL 35244

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Courtney Cochran

Date of Birth 04 / 24 / 1987

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.

Courtney Cochran
Signature of Patient

04 / 17 / 2016
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 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 17 day of November 2014

Print Patient Name Courtney Cochran

Signature Courtney Cochran

Relationship to Patient _____

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

Name: Courtney Cochran

Date of Birth: 04/24/1987

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 Joshua Cochran

☐ 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: 334-224-4207

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) Mon-Fri between (time) 0800-1700

Signed:

Courtney Cochran

Date: 11/17/2016

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 02-09-09

Are you an AUM student? ☒ YES ☐ NO

Name: Courtney Bagents

Social Security Number: 420-27-0488

Birth Date: 04-24-1987

Local Phone Number: 334-315-2420

Alternate Number: N/A

Local Address: 521 MYRTLE DRIVE
425 N. BURNING DR. APT. 807

Box Number: _____

City: Montgomery

State: AL

Zip Code: 36117

Permanent Address: same as above

City: _____

State: _____

Zip Code: _____

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

Sex: Male ☐ ☒ Female (Please Circle)

Primary Physician: Raghu Mukkumala

City: Montgomery

Phone #: _____

Patient's Employer: _____

Work #: _____

Parent's or Spouse's Name (Circle which) Josh Cochran

Phone #: 706-889-8115

Parent's or Spouse's Employer: Terry Bagents

334-303-3517

334-277-1665

Work #: _____

Emergency Contact: Josh Cochran
Terry Bagents

Relationship: Spouse
mom

Phone #: 706-889-8115
334-303-3517
334-277-1665

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

Courtney Bagents

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: Courtney Baggett
DATE: 06-30-09

SIGNATURE: _____

DATE: _____

SIGNATURE: Courtney Baggett
DATE: 07-02-09

SIGNATURE: _____

DATE: _____

SIGNATURE: Courtney Baggett
DATE: 02-17-10

SIGNATURE: _____

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SIGNATURE: Courtney Baggett
DATE: 03-11-10

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