

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 01/26/2018 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Lakeshia Dillard

Social Security Number: 417 25 0855 Birth Date 02/14/1979

Local Phone Number: 334 244 3483 Alternate Number: 334 233 1443

Local Address: 4078 Fitzpatrick Blvd Box Number _____

City: Montg State: AL Zip Code: 36116

Permanent Address: 4078 Fitzpatrick Blvd

City: Montg State: AL Zip Code: 36116

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

Sex (Please Circle): Male Female

Primary Physician: Daniel Moore City: Montg, AL Phone #: 334 396 9100

Patient's Employer: AUM Work #: 334 244 3483

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

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

Emergency Contact: Kenya Howard Relationship: sister Phone #: 334 531 9458

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 Lakeshia D Dillard

Policy Number QAU830338040 Group Number 37655

Insurance Company Address 450 Riverchase Parkway East
Birmingham, AL 35244

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 _____ day of _____ 20_____.

Print Patient Name Lakeshia Dillard

Signature L. Dillard

Relationship to Patient Self

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

Name: LaKeshia Dillard Date of Birth 02/14/19

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: Kenya Howard

☐ 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) - 244 - 3483

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) Monday - Friday between 8am and 5pm times.

Signed: L Dillard

Date: 01/26/2018

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Lakeshia Willard Date of Birth 02 / 14 / 79

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.


Signature of Patient

01 / 26 / 2018
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient