

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 2-5-2018 Are you an AUM Student? ☐ Yes ☒ No S-Number: \_\_\_\_\_

Name: CYNTHIA WATSON Birthdate: 1-17-67

Main Phone Number: 334-544-4238 Alternate Phone Number: Same

Local Mailing Address: 1178 Lakewood Drive Box or APT #: \_\_\_\_\_

City: Montgomery State: AL Zip Code: 36109

Permanent/Home Address: Same Box or APT #: \_\_\_\_\_

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

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

Sex (Please Circle): Male Female Gender: Male Female

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Employer: Brantwood Children Home Work Phone #: 334-265-0784

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

Parent's or Spouse's Employer: N/A Phone #: \_\_\_\_\_

Emergency Contact: Caryn Watson Relationship: Sister Phone #: 251-253-1606

How did you hear about the clinic (Circle which): Friend Faculty/Staff Orientation Other: \_\_\_\_\_

## INSURANCE INFORMATION

Do you have health insurance? ☐ YES ☐ NO

*If yes, please give your card to the front desk in order for a copy to be made for your chart.*

Insurance Company: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Policy or Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

# AUM STUDENT HEALTH CENTER

## CONSENT FOR SERVICES FORM

Patient Name: Cynthia Watson Date of Birth: 01 / 17 / 1967  
Day Month Year

### 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 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.

Cynthia Watson  
Signature of Patient

02 / 05 / 2018  
Day Month Year  
Date of Signature

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

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

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

Name: Cynthia Watson Date of Birth 02/05/2018

**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): \_\_\_\_\_

[x] Other: Carolyn Watson Sister

[ ] 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 [x] my cell number: (334)-544-4238

If unable to reach me:

[x] 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) Anytime between \_\_\_\_\_ and \_\_\_\_\_ times.

Signed: Cynthia Watson

Date: 02/05/2018

# AUM Student Health Services

## PATIENT HIPPAA 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 (HIPPA). 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 involve 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 HIPPA. 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 with 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 05 day of Feb 20 18.  
(day) (month) (last two digits of the year)

Print Patient's Name: Gynthia Watson

Signature: Gynthia Watson

Relationship to Patient (if you are the patient, write "self"): \_\_\_\_\_