

AUM NURSING CARE CENTER

PATIENT INFORMATION (Print Please)

Date: 3/2/07
Name: Melissa Beck
Student ID #: 223-15-2100 Birth Date: 2/4/73
Local Phone Number: 361-4569 Alternate Number: 244-3600 3652
Local Address: 130 Galehad St. Box Number: _____
City: Prattville State: AL Zip Code: 36067
Permanent Address: _____
City: _____ State: _____ Zip Code: _____
Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other _____
Sex: Male ☐ Female ☒
Primary Physician: Dr. Banach City: Prattville Phone #: 361-3090
Patient's Employer: AUM Work #: 244-3660 3652
Parent's or Spouse's Name: (indicate which one) Chris Beck Phone #: 717-1666
Parent's or Spouse's Employer: Hoveround Work #: 717-9665
Emergency Contact: Rhonda Morton Relation Friend Phone #: 271-3923
How did you hear about our clinic? Friend ☐ Faculty Staff ☒ Orientation ☐ Other: _____

INSURANCE INFORMATION

Do you have health insurance? Yes ☒ No ☐ If yes, please complete the following information.

Name of insured: Melissa Beck Relationship to patient: Self
Insurance Company: BC/BS
Policy Number: PPA806667578 Group Number: 37655
Insurance Company Address: 450 Riverchase Pkwy E.
City: Birmingham State: AL Zip Code: 35244

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 Nursing Care Center.

Signature X: Melissa Beck
Signature of patient or parent/guardian, if patient is a minor

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Melissa Reck Date of Birth 02/04/73

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 Reck
Signature of Patient

9/20/16
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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

Name: Melissa Reck Date of Birth: 02/04/73

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 Chris Reck

☐ 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: 334-207-4112

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) day between (time) 8-5

Signed: Melissa Reck Date: 02/19/15

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 19 day of February 2015.

Print Patient Name Melissa Reck

Signature Melissa Reck

Relationship to Patient Self

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: Melissa Reck
DATE: 10/8/07

SIGNATURE: Melissa Reck
DATE: 11/30/07

SIGNATURE: Melissa Reck
DATE: 11/16/08

SIGNATURE: Melissa Reck
DATE: 11/23/09

SIGNATURE: Melissa Reck
DATE: 12/08/09

SIGNATURE: Melissa Reck
DATE: 7/11/12

SIGNATURE: Melissa Reck
DATE: 9-30-14

SIGNATURE: Melissa Reck
DATE: 2-19-15

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