

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 01/05/2018 Are you an AUM student? YES NO Student ID # 500347311

Name: PYARAM SHRIVARDHAN

Social Security Number: _____ Birth Date: 03/16/1995

Local Phone Number: 334-552-2642 Alternate Number: _____

Local Address: 6910 H Wrangler Road Box Number: _____

City: Montgomery State: Alabama Zip Code: 36117

Permanent Address: H.No-4-3-118, Rd.No.6, Mallikarjuna Colony

City: Hyderabad State: TELANGANA, INDIA Zip Code: 500086

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

Sex (Please Circle): (Male) Female

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: _____ Work #: _____

(Parent's) or Spouse's Name (Circle which) PYARAM GOVERDHAN Phone #: +919490425054

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

Emergency Contact: P HARIVARDHAN Relationship: Brother Phone #: 408-637-8538

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 _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name PYARAM SHRIVARDHAN Date of Birth 03/16/1995

General Consent for Treatment

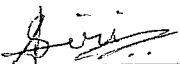
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

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

01/05/2018

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.

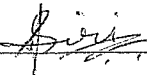
I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change 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 5th day of January 2018.

Print Patient Name PYARAM SHRIVARDHAN

Signature 

Relationship to Patient Self

AUM Student Health Services Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
 - File a complaint with your provider or health insurer, or
 - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared;
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination;
- To pay doctors and hospitals for your healthcare;
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object;
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer;
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

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

Name: PYARAM SURIYARDHAN Date of Birth: 03 1 16 1995

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 Parents _____

☐ 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: 334-552-2642

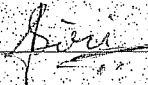
If unable to reach me:

☒ you may leave a detailed message.

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed:  Date: 01 10 2018

AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTORY

Date 01/05/2018

Name P. VARAM SRIWARDHAN

1. What is the reason for your visit today? TB Skin Test
2. Is there anything about you and your health that we need to know? No
- *3. List medicine, drugs, or food you are allergic to: _____
- *4. List any medicines or drugs you take: _____
5. Have YOU or anyone in your family had any of the following: (circle)

heart disease

diabetes/sugar

tuberculosis

nerve or mental problems

high blood pressure

blood problem or disease

birth defects

asthma

stroke

cancer

mental retardation

died before age 50

other "family" disease

No

6. Have you ever been in the hospital? No Why? _____
7. Have you ever had surgery? No Why? _____
8. Have you ever had a serious accident? No
9. Have you had serious or recent problems with:

ears or throat

☒ NO YES

cough

☒ NO YES

kidneys

☒ NO YES

gallbladder

☒ NO YES

allergies

☒ NO YES

thyroid

☒ NO YES

weight loss

☒ NO YES

liver

☒ NO YES

lung infections

☒ NO YES

skin problems

☒ NO YES

ulcers

☒ NO YES

depression

☒ NO YES

headaches

☒ NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? ☒ NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? ☒ NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? ☒ NO YES
If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
How much smokeless tobacco do you use a day? _____
- *13. How often do you drink beer, wine, wine coolers, or liquor?
Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
If you drink beer, wine, wine coolers, or liquor, do you have:
(less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? ☒ NO YES
- *15. Have you ever used I.V. drugs? ☒ NO YES
16. Have you ever had a blood transfusion? ☒ NO YES
17. Do you have any tattoos? ☒ NO YES
18. Have you ever been treated for a venereal disease? ☒ NO YES
19. Have you had more than one sex partner in the past 5 years? ☒ NO YES
20. Have you ever had sex with a member of your own sex? ☒ NO YES
21. Have you had or been around anyone with hepatitis? ☒ NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? ☒ NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
How often do you have your periods? _____ Are they regular? _____
How many days do they last? _____
Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? ☒ NO YES
Do you check them regularly? ☒ YES NO
- *C. How many times have you ever been pregnant? _____ How many children are living? _____
Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? ☒ NO YES
Were any of your children premature? ☒ NO YES
How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
diaphragm? NO YES
- E. Did you have problems with any of these methods? ☒ NO YES
- F. Have you ever had an abnormal PAP smear? ☒ NO YES

Health Center Check-In

Student name: PIYARAM SHRIVARDHAN

Student ID: 500347311

Date: 01/05/2018

Student should return: _____

Date student completed testing: _____

Signature of Health Center Official: _____