

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 1-15-16 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Allie Byrd

Social Security Number: _____ Birth Date: 12-22-99

Local Phone Number: 334-202-8543 Alternate Number: 334-202-8543

Local Address: 2280 Guthrie Way Box Number _____

City: Montgomery State: AL Zip Code: 36106

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: Dr. Hughes City: Montg Phone #: 277-6624

Patient's Employer: _____ Work #: _____

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

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

Emergency Contact: _____ Relationship: _____ Phone #: _____

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 Allie Byrd Date of Birth 12/22/99

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.

Allie Byrd
Signature of Patient

1/15/10
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 15 day of Jan 20 16.

Print Patient Name Allie Byrd

Signature Amy Tyner

Relationship to Patient Mother

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

Name: Allie Byrd Date of Birth: 12, 22, 99

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 Amy and David Tyner

☐ 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: 202-8543

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) 11:30-1

Signed: Amy Tyner Date: 1, 15, 16

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 1/15/16 TIME: 0 PT. HISTORY REVIEWED / D. DATED: 1

PATIENT NAME: Allie Byrd DOB: AGE:

PRESENT COMPLAINT: Pt traveling to Haiti & mother on a mission trip. Is up to date on all vaccines and only needs a prescription for typhoid vaccine today. (will be
LMP: Now

MEDICATIONS:

Temp	Pulse	Resp	B/P	HT	WT	Allergies
						<u>WKMA</u>

INITIAL VISIT

Skin	<u>getting a prescription for malaria prophylaxis from pediatrician. AM</u>	RETURN VISIT
Sinuses		
Ears		
Eyes	<u>Reviewed instructions for vivotif with mother (Amy Tynes). AM</u>	
Nose		
Throat		
Neck/Back		
Heart		
Lungs		
Abdomen		
GU/GI		
Extremities		

DIAGNOSIS:	TESTS	RESULTS

CALL BACK:

PLAN:

PRACTITIONER SIGNATURE: STAFF SIGNATURE: *[Signature]*

AUDIT DATE: COMMENTS:

PHYSICIAN SIGNATURE:

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 1-15-16 Name Allie Byrd

1. What is the reason for your visit today Vaccination for travel
2. List allergies you have to medicines, foods or iodine: NA
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): NA
4. Have you had any of the following: (circle if this applies to you;):
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ No ☒
Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____
Spleen removed _____
Transplant recipient _____
Cirrhosis of the liver _____
Cancer _____
HIV _____
6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? Jacmel, Haiti
8. How long is your trip? Months _____ Days 5
9. When are you leaving on your trip? Feb. 10

FOR FEMALES ONLY

- A. Date of your last period? NW Have you had a hysterectomy? YES _____ NO ☒
- B. Are you currently pregnant? YES _____ NO ☒
What is your due date? _____
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO ☒
- D. Are you breastfeeding? YES _____ NO ☒