

AUM NURSING CARE CENTER

PATIENT INFORMATION (Please Print)

Date 8/4/00
 Name Erin Reilly Student ID# 554 551-61-0512
 Birth date 2/4/64 Local Phone Number 395-7690
 Local Address 6933 Oak Side Dr. 301-1130 cell
 City Montgomery State AL Zip Code 36117
 Circle one: ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Sex: M ☒ F
 Primary Physician _____ City _____ Phone # _____
 Patient's Employer AUM Work # 63586
 Parent's or Spouse's Name _____ Phone # _____
 Parent's or Spouse's Employer _____ Work # _____
 Emergency Contact: Kay Smith Relation Mother Phone # 514-4477
 How did you hear about our clinic? _____

INSURANCE INFORMATION

Do you have health insurance? YES NO
 If yes, please complete the following information:
 Name of insured _____ Relation to Patient _____
 Insurance Company _____
 Policy Number _____ Group Number _____
 Insurance Company Address _____
 City _____ State _____ Zip Code _____

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 Erin Reilly
 Signature of patient or parent/guardian, if patient is a minor

SERVICES CONSENT FORM

NAME: Erin Reilly
DATE OF BIRTH: 2/4/64

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: Erin Reilly
DATE: 8/4/00

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 8/7/00

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 8/7/00

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 8/11/00

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 9/11/00

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 4/17/01

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 2/10/05

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 2/9/05

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 7/3/07

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 7/29/11

SIGNATURE: _____
DATE: _____

SIGNATURE: Erin Reilly
DATE: 5/13/15

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

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 13 day of May 2015.

Print Patient Name Erin Reilly

Signature Erin Reilly

Relationship to Patient Me

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

Name: Erin Reilly Date of Birth: 5.13.15

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 mom Dr. Eric Graves

☐ 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: 301-1130

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) All day between (time) _____

Signed: Erin Reilly Date: 5.13.15