

# AUM STUDENT HEALTH CENTER - EMPLOYEES

## PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: July 19, 2018 Are you an AUM Student? ☐ Yes ☒ No S-Number: \_\_\_\_\_

Name: Kia Holloway Birthdate: 10-02-66

Main Phone Number: 205 200 5113 Alternate Phone Number: 334 244 3221

Local Mailing Address: 2746 Fisk Rd Box or APT #: \_\_\_\_\_

City: Montgomery State: AL Zip Code: 36111

Permanent/Home Address: Same as above 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: Leslie Harris City: Montgomery Phone #: 334 284 5211

Patient's Employer: Aum Work Phone #: \_\_\_\_\_

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

Parent's or Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: Johnisha Harris Relationship: daughter Phone #: 334 590 6228

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: Kia Holloway Date of Birth: 02 / 10 / 66  
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.

[Signature]  
Signature of Patient

19 / 7 / 18  
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: Kia Holloway Date of Birth 10/02/66

**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): Jahnisha Harris, LaDamon Holloway

☐ 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: (205)-200-5113

If unable to reach me:

☒ 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: \_\_\_\_\_

Date: 07/19/16

# 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 16<sup>th</sup> day of July 20 18.  
(day) (month) (last two digits of the year)

Print Patient's Name: Kia Holbrook

Signature: [Signature]

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