



**AUBURN UNIVERSITY  
AT MONTGOMERY**

**WARHAWK HEALTH SERVICES**

**Patient Information Update Form**  
**(Please Print Legibly)**

Date: 1/4/24 Student Number: S00217915 Birthdate: 7/10/1997  
Last Name: Koda First Name: Alexandra  
Phone Number: 334-462-9504 AUM Email: akoda@aum.edu  
Local Address: 1620 Limestone Ct. Box or APT#: —  
City: Montgomery State: AL Zip Code: 36117  
Marital Status: Single ☒ Married ☐ Divorced ☐ Widowed ☐ Other: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone# \_\_\_\_\_

**Insurance Information**

Do you have health insurance? Yes ☒ No ☐

If Yes, give your card to the front desk in order for a copy to be made for your chart and complete this section.

Insurance Company: BCBS Policy or Contract Number: QA1850516240  
Group Number: 37455 Policy Holder Name: Alexandra Koda  
Policy Holder Date of Birth: 07/10/1997 Relationship to Policy Holder: self  
Insurance Company Address: 450 Riverchase Parkway East, Birmingham, AL 35244

**Medical History**

Do you have any allergies, medical conditions, or procedures: (Include hospitalization, illnesses, and surgeries)

allergic to penicillin, sinus surgery in 2019

Please list any medications you are currently taking:

birth control (pill) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **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 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 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 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.

### **General Consent for Treatment**

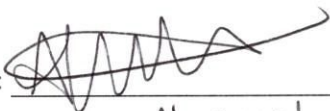
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

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 Warhawk Health Services. 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: 

Date: 1/4/24

Print Patient's Name: Alexandra Koda

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

**Warhawk Health Services**  
**Medical Information Release Form (HIPAA Release Form)**

Name: Alexandra Koda Date of Birth 7/10/1997

**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:

Name: Anthony Wilson Phone: 334-425-8725 Relationship: Partner

Name: Adrienne Koda Phone: 334-657-1925 Relationship: Mother

Name: David Koda Phone: 334-657-2032 Relationship: Father

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

☐ 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)-462-9504

If unable to reach me:

☐ Please send me an email

☐ Please leave me a message to return your call

☒ Please leave me a detailed message

☐ Other

The best time to reach me is:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Morning ☐ Early Afternoon ☐ Late Afternoon ☒ Anytime

Signature: \_\_\_\_\_

Date: 1/4/24