

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 2/9/15 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Amanda Brasington

Social Security Number: 418-35-3134 Birth Date 3-23-85

Local Phone Number: 312-4907 Alternate Number: 244-3067

Local Address: 9065 Black Cherry Trail Box Number _____

City: Pike Road State: AL Zip Code: 36064

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Dr. Hendon City: Montgomery Phone #: _____

Patient's Employer: AUM Work #: 244-3067

Parent's or Spouse's Name (Circle which) Leon Brasington Phone #: 399-1930

Parent's or Spouse's Employer: Mont Water Works Work #: _____

Emergency Contact: Leon Brasington Relationship: Husband Phone #: 399-1930

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 _____

SERVICES CONSENT FORM

NAME: Amanda Brasington
DATE OF BIRTH: 3-23-89

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: Amanda Brasington SIGNATURE: _____
DATE: 2/9/15 DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ DATE: _____

SIGNATURE: _____ SIGNATURE: _____
DATE: _____ 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 2 day of 9 2015.

Print Patient Name Amanda Brasington

Signature Amanda Brasington

Relationship to Patient _____

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

Name: Amanda Brasington Date of Birth: 3/23/85

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 Leon Brasington

☒ Child(ren) Eliza Brasington

☐ 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: _____

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: Amanda Brasington Date: 2/9/15