



**AUBURN UNIVERSITY  
AT MONTGOMERY**

**WARHAWK HEALTH SERVICES**

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

Date: Dec 15 2022 Student Number: 500399575 Birthdate: Dec 22 1984

Last Name: BOGA First Name: BINDU PRIYA

Phone Number: 334 731 3506 AUM Email: boga.bindupriya@gmail.com

Local Mailing Address: 149 G Saddle Back Ridge Dr Box or APT#: 149 G

City: Montgomery State: Alabama Zip Code: 36117

Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: BINESH KUMAR Relationship HUSBAND Phone# 334 669 7998

**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: \_\_\_\_\_ Policy or Contract Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

**Medical History**

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

Please list any medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **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 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: 15 / 12 / 2022

Print Patient's Name: BOGIA BINDU PRIYA

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

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

Name: BOGA BINDU PRIYA Date of Birth 15/12/2022

**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: BINESH KUMAR Phone: 3346697998 Relationship: HUSBAND

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

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

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)-731-3506

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: 15/12/2022