

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: May 1, 2018 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Kaitlyn Musser Birthdate: June 7, 1997

Main Phone Number: (334) 207-5317 Alternate Phone Number: N/A

Local Mailing Address: 107 Northlake St Box or APT #: N/A

City: Pike Road State: AL Zip Code: 36064

Permanent/Home Address: 107 Northlake St Box or APT #: N/A

City: Pike Road State: AL Zip Code: 36064

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

Sex (Please Circle): Male Female Gender: Male Female

Primary Physician: Dr. Daniel Moore City: Montgomery Phone #: 396-9100

Patient's Employer: student Work Phone #: (334) 272-5820

Parent's or Spouse's Name (Circle which): Chad Musser Phone #: (334) 202-2289

Parent's or Spouse's Employer: AUM Phone #: (334) 202-2289

Emergency Contact: Chad Musser Relationship: Father Phone #: (334) 202-2289

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: BlueCross Blueshield of Alabama Name on Card: William C. Musser

Policy or Contract Number: QAU886571513 Group Number: 37655

Insurance Company's Address: 450 Riverchase Parkway East Birmingham, AL
35244

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: Kaitlyn Musser

Date of Birth: 7 / 6 / 1997
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.

Kaitlyn Musser
Signature of Patient

1 / 5 / 2018
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: Kaitlyn Musser Date of Birth 6/7/1997

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:

☐ Spouse: _____

☐ Child(ren): _____

☒ Other: Chad Musser

☐ 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)-207-5317

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) any time between _____ and _____ times.

Signed: Kaitlyn Musser

Date: 5/1/2018

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 1 day of May 20 18.
(day) (month) (last two digits of the year)

Print Patient's Name: Kaitlyn Mussel

Signature: Kaitlyn Mussel

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

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Kaitlyn Musser

DATE OF BIRTH 6 / 7 / 97
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Kaitlyn Musser DATE 5/1/18

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.