

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 3-18-13 Are you an AUM student? ☒ YES ☐ NO Student ID # S00085499

Name: Carlissa Brown

Social Security Number: 417-39-8283 Birth Date 1-14-1992

Local Phone Number: (334) 465-0234 Alternate Number: _____

Local Address: 1533 West Helicon Rd. Box Number _____

City: Grady State: AL Zip Code: 36036

Permanent Address: 1533 West Helicon Rd.

City: Grady State: AL Zip Code: 36036

Marital Status: Single ☒ Married ☐ Divorced ☐ Widowed ☐ Other _____

Sex: Male ☐ Female ☒ (Please Circle)

Primary Physician: Family Care City: Livorno Phone #: _____

Patient's Employer: Taco Bell Work #: _____

Parent's or Spouse's Name (Circle which) _____ Phone #: _____

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Ethelene Winata Relationship: guardian Phone #: (334) 537-4777

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.

CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Student Health Center (Nursing Care Center).

Signature X Carlissa Brown

Signature of patient or parent/guardian, if patient is a minor.

SERVICES CONSENT FORM

NAME: _____

DATE OF BIRTH: _____

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: Carissa Brown

DATE: 3-18-13

SIGNATURE: _____

DATE: _____

SIGNATURE: Carissa Brown

DATE: 3-20-13

SIGNATURE: _____

DATE: _____

SIGNATURE: Carissa Brown

DATE: Nov 19, 2013

SIGNATURE: _____

DATE: _____

SIGNATURE: Carissa Brown

DATE: Nov 19, 2013

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SIGNATURE: Carissa Brown

DATE: Nov 21, 2013

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DATE: _____

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DATE: _____

Last Name BROWN

First Name CARLISSA

Date of Birth 01/14/1992

CONSENT FOR SERVICES and MEDICAL RECORDS INFORMATION

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CVS/pharmacy("CVS") to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

HIPAA AUTHORIZATION: I voluntarily authorize and direct my health care provider at CVS/pharmacy ("CVS") to use and to disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (standing order provider STANFORD, MICHAEL), my Primary Care Physician (), my insurance plan, health systems and hospitals, and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance) during the term of this HIPAA Authorization ("Authorization"). This Authorization permits CVS to disclose only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health information is disclosed to the recipients identified above. CVS cannot guarantee that any recipient will not redisclose my health information to a third party that may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by CVS. I understand that this Authorization will remain in effect until the term of this Authorization expires as noted above or I provide a written notice of revocation to CVS to the address provided in the CVS Notice of Privacy Practices. The revocation will be effective immediately upon CVS receipt of my written notice, except that the revocation will not have any effect on any action taken by CVS in reliance on this Authorization before it received my written notice of revocation.

X

Date:

*Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)***Vaccine Administration Information:**

Administration Date 09/26/2015

Vaccine AFLURIA 2015-2016 SYRINGE

Manufacturer

CSL BIOTHERAPIE

Lot # US9308

Exp. Date 06/2016

Route IM

Site

Left Deltoid

Volume (mL) 0.50

VIS Version Date 08/07/2015

Date VIS Given to Pt 09/26/2015

Diermayer Daniel, RPh

Administering Immunizer Name & Title

Administering Immunizer Signature