# ERAU Wellness Center
# HIPAA Form
# Confidential Communication Request and Patient Notification Process

**Patient Name:**_____

**Student ID#:**_____

**DOB:**_____

**Phone#**:_____

☐ **Permission to call the above number to leave messages regarding tests results and appointments**

☐ **Permission to receive text reminders for appointments**

Please read and initial the following statements:

_____I hereby authorize release of information required by treating physicians, counseling department, athletic trainers, ____Dean of Students office, ____ faculty, _____ROTC,_____ flight line, ___and, disability_____, and insurance carriers for the above named patient.

_____ I understand that visits to outside facilities are not paid for by the Wellness Center. I also understand that I am responsible for the payment of any tests sent to outside laboratories.

_____I understand I may receive a copy of the Privacy Rules from the ERAU Wellness Center, if requested. I hereby authorize the Wellness Center and/or their representatives to discuss my medical care information with the persons listed below. I may revoke this at any time by giving written notification to the ERAU Wellness Center.

Permission to give verbal protected health information to the following person(s):
Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care.

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

Signature:_____ Date:_____

# INSURANCE VERIFICATION FORM 19-20

Today's Date:_____

## PATIENT INFORMATION

Patient Name:_____ Phone#:_____

Student ID#_____ Date of Birth:_____

Prescott Address:_____City:_____ State:_____

ZipCode:_____ Campus Box # _____

## INSURANCE INFORMATION

**(Please give your insurance card to the receptionist)**

Primary Insurance Company:_____

Policy/Member ID#:_____ Group#:_____

Insurance address:_____

Are you the Policy holder? (circle one) ☐ YES ☐ NO

Policyholder's Name:_____ Date Of Birth:_____

Street address:_____

City:_____ State:_____ Zip Code:_____

Home phone#:_____

Patient's relationship to the Policyholder? (circle one)

SELF ☐ CHILD ☐ SPOUSE ☐ OTHER ☐

**ERAU WELLNESS CENTER PRESCOTT**

NAME_____BIRTHDATE_____
BOX#_____ STUDENT ID#_____ PHONE#_____
DRUG ALLERGIES_____
SPECIALMEDICAL PROBLEMS_____
MEDICATIONS_____

I, HEREBY GIVE PERMISSION TO ERAU WELLNESS CENTER'S MEDICAL/NURSING STAFF TO ASSESS MY CONDITION, DISPENSE ANY MEDICATIONS AND TREATMENTS THAT MAYBE NECESSARY.

SIGNATURE _____ DATE_____

## Summary Form

Patients Name: _____

Date of Birth: _____

Student ID #: _____

Drug Allergies/Sensitivities: _____

Emergency Phone #: _____ Contact Person/Relationship: _____

| ICD Code | Chronic Medical Problem List | Date | Past Surgical History | Date |
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| | **Chronic Medication list** | | **Significant Family History** | |
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