Auburn University Medical Clinic

400 Lem Morrison Drive
Auburn University, AL 36849-5349

Telephone: (334) 844-4416 *AUMC is an affiliate of East Alabama Medical Center* **Fax: (334) 844-6126**

Welcome to the Auburn University Medical Clinic! We are committed to providing a full range of primary and urgent care services including initial diagnostic services for illnesses and injuries, immediate and follow-up assessment, preventive care services, immunization and women's health services. Services are provided on an appointment basis. Walk-ins will be evaluated and given appointments or seen immediately based on the urgency of the presenting problem or condition. The Auburn University Medical Clinic facility includes a CLIA certified laboratory, x-ray, a Women's Health center, allergy and immunization services, and pharmacy services. The clinical staff consists of fully licensed and credentialed physicians, nurse practitioners, physician assistant, registered nurses, technicians and other support staff. Services are provided on a fee-for-service basis with on-site billing services provided for students to facilitate insurance reimbursement. Cash, checks, Tiger Club, and major credit cards are accepted and payment plans are available. Services are available to all Auburn students, spouses and dependents, faculty, staff and visiting guests.

Hours of Operation: Monday –Friday 8 a.m. – 6 p.m.
Except Thursday 9 a.m. – 6 p.m.
Saturday 8 a.m. – 12 p.m.
(Hours Subject to Change)

To Make an Appointment: Please Call **(334) 844-4416**

WWW.AUBURN.EDU/AU_MEDICAL

ADDITIONAL INFORMATION

Local (Auburn) **Address, if known**:_____

Local (Auburn) **E-mail, if known**: _____

Local Telephone #s HOME: _____-_____-_____ WORK _____-_____-_____ CELLULAR _____-_____-_____

Employer: _____

Marital Status: _____ Divorced _____ Married _____ Separated _____ Single _____ Widowed

Student Status: _____ Full Time _____ Part Time Non Student Status: _____Faculty_____Staff _____Other

BILLING INFORMATION

Patient's Relationship to billing Person(s): _____ Self _____ Spouse _____ Child _____ Other

Name of Billing Person(s) _____
(First) (Middle) (Last)

Telephone #s **Home: _____-_____-_____ Work: _____-_____-_____ Cellular: _____-_____-_____**

Address _____
(Street / P.O. Box) (City) (State) (Zip)

I hereby authorize Auburn University Medical Clinic (AUMC) to release information from my medical records as may be required or requested by my insurance company, employer, or any other persons liable to AUMC for payment of all or part of the charges pertaining to my office visits. I also authorize AUMC to act as my agent when filing insurance claims on my behalf. I directly assign to AUMC all insurance benefits and agree that any benefits payments sent to me will be promptly forwarded to AUMC. I understand that I am responsible for all charges incurred at the Auburn University Medical Clinic regardless of the degree to which my insurance covers the services rendered.

Billing Disclosure – If you have insurance, balances will be filed with insurance companies under most circumstances. Items not fully paid or otherwise accounted for by an insurance company will be billed to you or your designated responsible party. After a period of time, uncollected balances may be collected through the Bursar's office, Tiger Club Card, and/or a collection agency. Holds may be placed on registration/graduation. **After 60 days, outstanding balances will become the patient's responsibility. If any checks are returned, there will be a "returned check" fee assessed for a minimum of $30.00.**

I understand that some or all of my expenses at Auburn University Medical Clinic may not be covered by my health insurance. I understand and agree to pay all co-pays at the time of service. I also understand that after 60 days, any patient **AND/OR** insurance balance becomes my responsibility. I hereby authorize Auburn University Medical Clinic to bill **ALL** outstanding balances over 60 days to my Tiger Club Account. If I choose to decline signing this document, I understand that a hold will be placed on my records for Graduation or Registration until all balances are paid in full. I agree that this agreement pertains to all visits to the Auburn University Medical Clinic.

_____ _____

PATIENT SIGNATURE **DATE**

MEDICAL INFORMATION FORM
AUBURN UNIVERSITY
(CONFIDENTIAL)

MEDICAL LEGAL DOCUMENT – Property of Auburn University Medical Clinic. Information may not be released to a third party unless a proper acceptable authorization is furnished to the Medical Clinic. This release must comply with State and Federal Regulations. Incomplete or inaccurate information may delay your clearance, cancel your registration, or cause improper decisions of your future medical care.

BEFORE YOU MAIL THIS FORM, be sure to COMPLETE BOTH SIDES...Sign...Have Your Parents Sign...Have Your Physician Sign

MAIL OR FAX TO: Auburn University Medical Clinic
ATTN: Medical Records
400 Lem Morrison Drive
Auburn University, AL 36849-5349

Phone: (334) 844-4416
Fax: (334) 844-6126

GENERAL INFORMATION

Name: _____ Social Security # ___ - ___ - ___
Last First Middle AU User ID/GID _____
Home Address _____ Home Phone _____
City _____ State _____ Zip _____
Date of Birth _____ Sex (circle one) M F Email Address _____
Emergency Contact – Name _____ **Relationship** _____
Telephone #s **HOME** _____ **WORK** _____ **CELLULAR** _____
Address _____
Street / P.O. Box City State Zip
Authorization for medical clinic to treat a minor student (under 19 years of age) _____
(Signature of parent or legal guardian)
List Allergies to medication or other items _____
Semester entering school (Semester / Year) _____

MEDICAL DOCUMENTATION

(REQUIRED)

TUBERCULIN SKIN TEST (PPD): This is required within eighteen (18) months prior to the first day of class of the semester you enter school. Having a chest x-ray is NOT an acceptable alternative, unless you previously had a positive PPD test. Anyone with a new or previous PPD test, according to Alabama Public Health Department guidelines, must provide the chest x-ray films AND an official report to AUMC. If you have initiated or completed medical treatment for your positive PPD, then please provide the documentation to us.

Date PPD given: _____ Date results read (must be no earlier than 48 hours and no later than 72 hours): _____

Results of PPD (MUST BE DOCUMENTED IN MM – NO EXCEPTIONS!) _____ mm **PLEASE, DO NOT WRITE "Negative"**

Chest x-ray results _____ Date of chest x-ray _____

Documentation / Evaluation _____

M.D. Printed Name _____ **CLINIC STAMP**

& **OR**

M.D. Signature _____

(REQUIRED)

2. MEASLES: Measles vaccine, Live, Attenuated IS required if born after 1957. Last dose must be since 1980.

Date _____ Type (circle): MMR MR M

M.D. Printed Name _____ **CLINIC STAMP**

& **OR**

M.D. Signature _____

**********(OPTIONAL)*******(OPTIONAL)******(OPTIONAL)*******(OPTIONAL)*******(OPTIONAL)*******(OPTIONAL)*******(OPTIONAL)*********

3. Tetanus Toxid – Date of last series or booster _____ **Meningococcal Meningitis Vaccine –** Date _____

Hepatitis B Series – Dates of Series _____ _____ _____

(In the event this documentation is not easily obtainable, all of the above services can be provided at the Auburn University Medical Clinic for a fee.)

INSURANCE INFORMATION

What is the name of your insurance company? _____

Subscriber# _____ Group # _____ Plan # _____

What is your insurance company's claims address _____

_____

Who is the policy holder? _____

What is your relationship to the policy holder? _____ DOB of Policy Holder _____

Does your plan require a co-payment? _____ If so, how much? _____

What are the limits (age, full time status, etc.) on the policy for your coverage as a student? _____

Does your plan provide for "out of area" coverage for you? _____ Does your plan provide prescription benefits? _____

Please attach a legible copy of the front and back of your insurance card.

Form: CL-PC-32 Revised 03/07