University Health Services

St. Vincent's at Samford

Health History

Today's date ____________________

Patient Name ____________________________________ **Date of Birth** ____________________

Reason for today's visit:

a.
b.
c.

Preferred Pharmacy:

Name: ____________________ Location: ____________________ Phone number: ____________________

Drug Allergies: ☐ No known drug allergies

a.
b.
c.
d.

Medications: ☐ None

Name	Dose / How often
a.	
b.	
c.	
d.	

Family Medical Issues: ☐ None

list any medical conditions your immediate family members have / had

Father
Mother
Brother(s):
Sister(s):

Social:	yes / no	how much / how often
Tobacco use		
Alcohol use		
Illicit Drugs		

Past Surgeries: ◻ None

surgery	date of surgery
a.	
b.	
c.	

Past Medical History / Problems: ◻ None

diagnosis	date diagnosed
a.	
b.	
c.	

Are you having any of these symptoms *currently*?

	Yes	No		Yes	No		Yes	No		Yes	No
General			**Cardiovascular**			**Genitourinary**			**Endocrine**		
Fever			Chest Pain			Incontinence			Fatigue		
Night Sweats			Arm pain on exertion			Difficulty Urinating			**Hematology**		
Weight Gain			Shortness of breath when walking			Hematuria (blood in urine)			Swollen Glands		
Weight Loss			Shortness of breath when lying down			Increase urinary frequency			Bruising		
Exercise Intolerance			Palpitations			**Musculoskeletal**			**Allergic**		
Eyes			Heart murmur			Muscle aches			Runny Nose		
Dry eyes			Edema/Swelling			Muscle weakness			Sinus problems		
Eye irritation			**Respiratory**			Joint pain			Itching		
Vision Change			Cough			**Dermatologic**			Hives		
ENMT			Wheezing			Abnormal moles			Sneezing		
Difficulty hearing			Short of Breath			Jaundice					
Ear pain			Coughing up blood			Rash					
Frequent Nosebleeds			**Chest/Breast**			**Neurologic**					
Sinus Problems			Abnormal lumps			Loss of consciousness					
Sore Throat			Tenderness			Weakness					
Bleeding Gums			Discharge			Numbness					
Snoring			**Gastrointestinal**			Seizures					
Dry Mouth			Abdominal pain			Dizzy					
Mouth Ulcers			Vomiting			Headache					
Oral abnormalities			Change in Appetite			**Psychiatric**					
Teeth problems			Diarrhea			Depression					
			Vomiting blood			Trouble Sleeping					
						Alcohol abuse					
						Relationship issues					

PATIENT INFORMATION

Patient Name: ______________________ **Samford I.D.:** 900____________

Date of Birth: ____/____/____ ☐Male ☐Female

Address: ______________________ **City/State/Zip:** ____________

Phone Number: (____) ______-______ **Email:** __________@__________.______
(must use same email address for patient portal registration)

Primary language: ______________ **Ethnicity/Race:** ______________

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed

Samford Status: ☐ Undergraduate Student ☐Graduate Student ☐Employee ☐Employee's spouse
Area of Study: ______________

INSURANCE INFORMATION

Legible copy of front and back of card required to be presented at the time of service
(Patient is designated as responsible party / guarantor unless noted otherwise)

Primary Insurance: ______________ **Policy Holder's Name** ______________

Policy/Member I.D.: ______________ **Policy Holder's Date of Birth:** ______________

Secondary Insurance: ______________ **Policy Holder's Name** ______________

Policy/Member I.D.: ______________ **Policy Holder's Date of Birth:** ______________

Authorization to pay benefits to physician / office: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to the provider when he/she accepts assignment.

Authorization to release medical information / referrals: I authorize my provider to release any information necessary for my course of treatment.

______________________________ ______________

Signature of Patient (or authorized representative) **Date**

Payments and Billing Process

Patient Name: ______________________ **Date of Birth:** ______________

Insurance

UHS is a participating provider with several health insurance plans. As a courtesy to our patients, UHS will bill participating plans when complete insurance information is received. Incomplete information will not be acceptable to file a claim. Please refer to the UHS site at www.samford.edu/healthservices for an updated listing of participating plans.

Payment

Payment may be made by VISA, MasterCard at the time of service. Co-pays and amount expected to not be covered by insurance are due at the time of service and may be paid using one of the approved credit cards or may also be charged to a student's account in Banner. The patient or designated responsible party is responsible for any balances not paid by their insurance carrier including deductibles and non-covered services. Payments received in full at the time of service for uninsured/non-covered visits will receive a 25% discount. Uninsured patients and patients with plans UHS is not considered a preferred provider must make an initial payment of $50.00 at the time of service. Any remaining balance will be billed to the patient or responsible party. Outstanding balances for international students will be posted to the student's account in Banner and e-billed through the Bursar's Office.

Non-Covered Services

Occasionally there are services that may be necessary for treatment of the patient's condition and maintenance of good health that are not covered by your insurance contract or that may be considered "medically unnecessary." The patient or designated responsible party is expected to pay for those services in full. Please be assured that the test and treatments ordered are only those your healthcare provider believes are necessary for your treatment and care.

Provider Services

Services provided by the Physician and the ARNP/PA are usually covered by private insurance. However, many individual and group contracts decide to exclude the ARNP/PA benefit in their contract, which means these services, are billable to the patient or responsible party directly. It is the patient's responsibility to understand the benefits of their insurance contracts.

Responsible Party

Unless otherwise designated, the patient is considered responsible for any balances not paid by insurance carriers, including co-pays, deductibles and non-covered services. It is the responsibility of the patient, if required by their insurance carrier, to obtain pre-certification or referral prior to visiting UHS. Questions concerning benefits must be directed to your insurance company.

Outstanding Balance

Patients with an account balance greater than ninety days past due will have the balance due placed on their student account. The Bursar balance/hold may prevent students from registering for the next semester, receive transcripts, participate in commencement, or receive a diploma until past due amounts are cleared. Past due amounts assigned to a collection agency may be reported to the credit bureaus and patients are responsible for attorney fees, collection fees and interest.

I have read your payment policy and agree to pay for the services outlined above as indicated by my signature.

______________________________ ______________

Patient or Responsible Party Signature **Date**

Pt Name: ______________________ DOB: ____________

Acknowledgement of Receipt of Joint Notice of Health Information Privacy Practices

By signing below, I acknowledge that I have received St. Vincent's Joint Notice of Health Information Privacy Practices.

______________________________ ____________________

Signature of Patient or Legal Representative Date

The privacy, security and confidentiality of your health information are important to us. Please let us know how you prefer us to contact you with results, questions, or appointment reminders.

Please select and number in the order we should attempt: **Phone Number:**

____ Home phone - Can we leave a message? ☐ Yes ☐ No ____________________

____ Cell phone - Can we leave a message? ☐ Yes ☐ No ____________________

____ Can we text you appointment reminders? Yes ▫ No ▫

____ Email: ____________________

____ Mail to home address

____ Telephone and message to another person (Please name ____________________) ____________ ____

____ Other ____________________

Please list any other persons to whom we may discuss your healthcare treatment and/or payment information. Many patients take this opportunity to list a spouse and/or an adult child or caregiver who often participate in their healthcare decisions and payment.

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

***Student Athletes: Please fill out additional HIPAA release for Samford Athletics**

UNIVERSITY HEALTH SERVICES
St. Vincent's at Samford™

AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT FOR TREATMENT

I hereby voluntarily consent to outpatient care from Samford University Health Services encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Samford University Health Services' medical providers and staff, as is necessary in the medical staff's judgment. I understand that during the course of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

Patient Name (print):________________________________ Patient Date of Birth:______________

Patient Signature:__________________________________ Today's Date:___________________