maccc
acu medical and
counseling care center

HEALTH RECORD FORM

Abilene Christian University Medical Clinic
ACU Box 28154
Abilene, Texas 79699-8154
Phone: 325-674-2625
Fax: 325-674-6998

STUDENT'S LAST NAME **FIRST NAME** **MIDDLE NAME** **GENDER**

BANNER I.D. NUMBER **DATE OF BIRTH** **SOCIAL SECURITY NUMBER**

ADDRESS

CITY STATE COUNTRY ZIP

PARENT / GUARDIAN / EMERGENCY CONTACT RELATIONSHIP PHONE

ADDRESS OF PARENT / GUARDIAN / EMERGENCY CONTACT

Medical History

1. Please list all allergies to food, medicines, animals or environmental triggers and describe the reaction (i.e. rash, wheezing, etc.):

Or check here if you have no allergies. ☐

2. Please list all surgeries with dates performed:

Or check here if you've had no surgeries. ☐

3. Please list all medical conditions and diagnoses along with treatment used. List medicines routinely taken by giving the name, dose (mg) and frequency. Include over the counter and nutritional supplements:

Or check here if you don't take medicines routinely. ☐

4. Please describe any prior or current treatment by a mental health provider such a s a psychiatrist, psychologist or counselor:

Or check here if you've never seen a mental health provider. ☐

Medical History

Have you had any of the following? Please answer each, commenting on all positive replies below:

1.	☐ YES	☐ NO	Mononucleosis	18.	☐ YES	☐ NO	Bone / Joint Injury
2.	☐ YES	☐ NO	Hay Fever, Allergies	19	☐ YES	☐ NO	Disease of Joints / Arthritis
3.	☐ YES	☐ NO	Asthma	20.	☐ YES	☐ NO	Back Problems
4.	☐ YES	☐ NO	Eye / Vision Problems	21.	☐ YES	☐ NO	Stomach / Intestinal Problems
5.	☐ YES	☐ NO	Ear, Nose, Throat Problems	22.	☐ YES	☐ NO	Cancer
6.	☐ YES	☐ NO	Insomnia	23.	☐ YES	☐ NO	Liver Disease
7.	☐ YES	☐ NO	Anxiety	24.	☐ YES	☐ NO	Diabetes
8.	☐ YES	☐ NO	Depression	25.	☐ YES	☐ NO	Thyroid Disorder
9.	☐ YES	☐ NO	Eating Disorder	26.	☐ YES	☐ NO	Epilepsy / Seizures
10.	☐ YES	☐ NO	Migraine Headache	27.	☐ YES	☐ NO	Sexually Transmitted Infection
11.	☐ YES	☐ NO	Head Injury / Concussion	28.	☐ YES	☐ NO	Kidney Disease / Stone
12.	☐ YES	☐ NO	Anemia	29.	☐ YES	☐ NO	Kidney Infection
13.	☐ YES	☐ NO	Heart Disease	**For Females Only:**			
14.	☐ YES	☐ NO	High Blood Pressure	30.	☐ YES	☐ NO	Menstrual Disorder
15.	☐ YES	☐ NO	ADHD / ADD	31.	☐ YES	☐ NO	Pregnancy
16.	☐ YES	☐ NO	Benign Tumor	32.	☐ YES	☐ NO	Breast Cyst
17.	☐ YES	☐ NO	Fainting				

33. ☐ YES ☐ NO Other _____

Have any of your relatives had any of the following?
If so, list relationship (parents, siblings, grandparents, uncles, aunts, etc.):

☐ YES	☐ NO	Cancer
☐ YES	☐ NO	Diabetes
☐ YES	☐ NO	Kidney Disease /Stones
☐ YES	☐ NO	Heart Disease
☐ YES	☐ NO	High Blood Pressure
☐ YES	☐ NO	Mental Health Problems
☐ YES	☐ NO	Asthma
☐ YES	☐ NO	Epilepsy / Convulsions
☐ YES	☐ NO	Sudden Death (non-accidental) before age 50

Student Signature _____ Date _____

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PATIENT REGISTRATION AND PRIVACY POLICY ACKNOWLEDGEMENT/DISCLOSURE

PATIENT INFORMATION AND COMMUNICATION OPTIONS			
Last Name:	First Name:	Middle Name:	Banner #:
Date of Birth:	Gender: ☐Male ☐Female	Eligibility: ☐Student ☐Faculty ☐Staff ☐ Dependent	
Local Address:		City:	TX Zip:
Cell Phone: ( )		May we leave a message? ☐Yes ☐No	Send you a message via email? ☐Yes ☐No
Email Address:			

Initials

PAYMENT OPTIONS: Please note that the ACU Medical Clinic does not file insurance claims but can provide you with the necessary documentation for you to file with your insurance company. Payment is required for services at the time they are rendered. We accept payment in the form of cash, credit card, check or you may charge the visit to your Banner/Student Account. Your signature below is verification that you understand this policy.

Initials

RELEASE OF MEDICAL INFORMATION: I authorize the release of medical information to my primary care physician and to consultants if needed. I also authorize the release of information if necessary to process insurance claims, insurance applications, and prescriptions. I grant the release of my existing ACU Medical records to Dr. Kyle Sheets and the ACU MACCC.

Initials

AUTHORIZATION FOR TREATMENT: I do hereby give permission for the ACU MACCC health providers (doctors, nurse practitioners, physician's assistants and nurses) to perform whatever diagnostic treatment, examinations, and procedures necessary to maintain my good health.

PROTECTED HEALTH INFORMATION: Pursuant to 45 CFR 164.501(a)(1)(iv) the Abilene Christian University Medical and Counseling Care Center (ACU MACCC), a covered entity (being a healthcare provider as defined by HIPAA), is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR 164.508.

I hereby authorize ACU MACCC to disclose the following information:

All health care information, reports, and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future, and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person(s) or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time.

I understand that I must be at least 18 years of age before I may make this authorization for release of protected health Information. I further understand that if I am not yet 18 years of age, I must have the approval and signature of my parent or legal guardian.

I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person(s) whose name(s) are written below, and the information, once disclosed, will no longer be protected by the rules created under HIPPA.

It is my intention to give full authorization for ANY protected medical information to the person(s) named in this authorization. This authorization shall remain in effect until my WRITTEN MODIFICATION and/or REVOCATION is received by ACU MACCC.

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PERSONS AUTHORIZED TO RECEIVE MY PROTECTED HEALTH INFORMATION (PHI)		
Last Name:	First Name:	Relationship:
Cell Phone:	Work Phone:	
Last Name:	First Name:	Relationship:
Cell Phone:	Work Phone:	

AUTHORIZATION OF RELEASE OF PHI AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES		
By signing below, I authorize the release of my protected health information as described above and acknowledge that I have received a copy of ACU MACCC's Notice of Privacy Practices, effective September 23,2013, on the date indicated below. If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to contact the Privacy Officer at 325-674-2625.		
Printed Name of Patient:	Signature of Patient:	Date Signed:
Signature of Patient's Representative:	Relationship to Patient	Reason Patient Unable to Sign: