



**John C. Longest Student Health Center  
Travel Clinic Work Sheet**

P.O. Box 6338; Mississippi State, MS 39762

662-325-8888 (fax); 662-325-7539 (phone)

Email [health@saffairs.msstate.edu](mailto:health@saffairs.msstate.edu)

[www.health.msstate.edu](http://www.health.msstate.edu)

Traveler: For us to best serve you this form needs to be filled out completely six to eight weeks before your departure.

Name: \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Itinerary: Departure Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Return Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Country	Length of Stay in country (weeks)	Cities Rural
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

High Altitudes: Yes No

Pregnant: Yes No

**MEDICAL PROBLEMS:**

**CURRENT MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_

**REASON FOR TRAVEL:**

\_\_\_\_\_

**IMMUNIZATION HISTORY:**

<b>Vaccine</b>	<b>Date of last booster</b>
Tetanus, DT, DPT	____/____/____
Polio, salk (injected)	____/____/____
PolioSabin (oral)	____/____/____
Typhoid (injected)	____/____/____
Typhoid (oral)	____/____/____
Cholera	____/____/____
Yellow Fever	____/____/____
MMR (measles, mumps, rubella)	____/____/____
Meningococcal	____/____/____
Plague	____/____/____
Japanese Encephalitis	____/____/____
Hepatitis A	____/____/____
Hepatitis B	____/____/____
Pneumococcal	____/____/____
Influenza	____/____/____
Varivax (Chicken pox)	____/____/____
Rabies	____/____/____

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Phone** (\_\_\_\_) \_\_\_\_\_

Patients are asked to pay for immunizations and medications given at the time of service. In addition, the following charges will be assessed:  
Preventive medicine fee of \$40.00 (includes travel counseling)  
In addition to cost of vaccine (which may vary), an administration fee of \$10.00 for each vaccination.  
We will file insurance claims as we do for other medical services.

Revised 6-2007

**John C. Longest Student Health Center**  
**Phone 662-325-2431 Fax 662-325-8888**

**P O Box 6338**  
**Mississippi State, Mississippi 39762**

Last Name		First	Middle	Social Security Number	
Local Address		City		State	Zip
Permanent Address		City		State	Zip
( ) -	Male	Female	Single	Married	Birthdate / /
Local Phone Number					Month Day Year

In an emergency, please contact:

Last Name		First	Middle	Address	
City		State	Zip	( ) -	( ) -
				Home Phone Number	Work Phone Number

Relationship: \_\_\_\_\_

**CONSENT TO TREAT**

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

\_\_\_\_\_  
Patient/Guardian Signature Date

**INSURANCE POLICY HOLDER**

(Person who owns policy)

Last Name		First	Middle Initial	Male	Female	Married	Single
Mailing Address		City		State	Zip		
( ) -	( ) -	Date of Birth / /		- -			
Home Phone Number	Work Phone Number	Month	Day	Year	Social Security Number		

Employer/School \_\_\_\_\_ Relationship to patient: Self Spouse Parent

**INSURANCE INFORMATION**

Insurance Company Name				
Mailing Address		City	State	Zip
Group Name/Number: _____		Insurance ID#: _____		
Policy Date C from _____ to _____				

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO PAY PHYSICIAN**

I understand that charges are due at time service is rendered. However, if doctor approves, I authorize any insurance benefits be paid to physician.

SIGNED: \_\_\_\_\_ Date: \_\_\_\_\_

**Health History**  
**Mississippi State University**

**Longest Student Health Center**

\_\_\_\_\_  
 Last Name                                      First                                      Middle                                      Social Security Number

**(CIRCLE AND/OR FILL IN THE APPROPRIATE BLANK)**

**FAMILY HISTORY**

Relationship	Age	Health (Good, Fair, Poor)	Occupation	Age at Death	Cause of Death
Father	_____	G    F    P	_____	_____	_____
Mother	_____	G    F    P	_____	_____	_____
Brother	_____	G    F    P	_____	_____	_____
Sister	_____	G    F    P	_____	_____	_____
Brother	_____	G    F    P	_____	_____	_____
Sister	_____	G    F    P	_____	_____	_____

**FAMILY ILLNESS**

Disease	Relationship (Grandparent, Parent, Brother, Sister, Other)				
Diabetes Mellitus	G	P	B	S	O
Kidney Disorders	G	P	B	S	O
Heart Disease before age 45	G	P	B	S	O
Asthma	G	P	B	S	O
Cancer	G	P	B	S	O
Other Heritable Disorders	G	P	B	S	O
High Blood Pressure	G	P	B	S	O

**SOCIAL HISTORY**

**Alcohol Usage** (circle one) Never    1/year    1/month    1/week    1/day                      **Drug Use:** (circle one) Yes    No  
 (One drink equals: 4 oz. wine, 12 oz. beer, or 1 oz. liquor)

**Tobacco**

\_\_\_\_\_ I don't smoke, dip or chew.  
 I smoke \_\_\_\_\_ cigarettes/day for \_\_\_\_\_ years.  
           \_\_\_\_\_ pipes/day for \_\_\_\_\_ years.  
           \_\_\_\_\_ cigars/day for \_\_\_\_\_ years.  
 I dip \_\_\_\_\_ cans/week for \_\_\_\_\_ years.  
 I chew \_\_\_\_\_ pouches/week for \_\_\_\_\_ years.  
 I quit \_\_\_\_\_ years ago.

**Seatbelts**

I use seatbelts \_\_\_\_\_ % of the time while riding or driving.

**Helmets**

I use helmets \_\_\_\_\_ % of the time while skating, cycles, or ATVs.

**Exercise**

I exercise enough to sweat and breathe hard \_\_\_\_\_ times/week

**REVIEW OF SYSTEMS (check those which apply to you)**

**Allergies**

\_\_\_\_\_ Penicillin  
 \_\_\_\_\_ Aspirins  
 \_\_\_\_\_ Sulfa  
 \_\_\_\_\_ Codeine  
 \_\_\_\_\_ Other \_\_\_\_\_

**Nervous System**

\_\_\_\_\_ Bulimia or Anorexia  
 \_\_\_\_\_ Head Trauma (concussion)  
 \_\_\_\_\_ Headaches  
 \_\_\_\_\_ Depression

**Operative Procedures**

\_\_\_\_\_ Tonsillectomy    \_\_\_\_\_ +/- Adenoidectomy  
 \_\_\_\_\_ Appendectomy  
 \_\_\_\_\_ Wisdom Teeth Extractions  
 \_\_\_\_\_ Hernia Repair  
 \_\_\_\_\_ Knee Surgery, Left or Right  
 \_\_\_\_\_ Other \_\_\_\_\_

**Infectious Diseases**

\_\_\_\_\_ Chicken Pox  
 \_\_\_\_\_ Mononucleosis

**Cardiovascular System**

\_\_\_\_\_ High Blood Pressure

**Last Pap Smear** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

# If you are a new patient, please read the following and complete the receipt at the end. Thank you.

## HIPAA NOTICE OF PROVIDER PRIVACY PRACTICES

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Mississippi State University's Longest Student Health Center must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your medical record. In general, when we release your health information, we must release only the information needed to achieve the purpose of the use or disclosure. Your personal health information will be available for release to you, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices a revised notice will be available upon request or at [www.health.msstate.edu/privacy](http://www.health.msstate.edu/privacy).

We can use your health information for the following purposes:

**Treatment** *Our clinicians may review your medical record to determine which treatment best addresses your health care needs. For example: Patients with chronic sore throat; the clinician may review your chart to determine your treatment, medication or surgery.*

**Payment** *In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis and the treatment provided to you. This requires that we pass this information to an insurer in order to receive payment for your medical bills.*

For example: We will submit to your insurer your name, date of birth, address, social security number, diagnosis and treatment received to receive payment for services you receive.

**Health Care Operations** *We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. For example: our clinicians review patient charts to determine the most effective, cost efficient treatment for specific diagnoses.*

In addition, for appointment reminders, we may look at your medical record to determine the date and time of your next appointment with us and communicate to you this information. We may also look at your medical information and decide that another treatment or new service we offer might interest you. For example: we may contact patients with tobacco use disorder to notify them that we have a tobacco use cessation program.

**Without your authorization, we can use your health information for the following purposes:**

**As required or permitted by law.** Sometimes we are required to report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example: We may have to report abuse, neglect, domestic violence or certain physical injuries or respond to a court order.

**For public health activities:** We may be required to report your health information to authorities to help prevent or control disease, injury or disability. This may include records pertaining to certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child neglect or abuse. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety. For example: Should you develop a contagious disease, such as measles, we may need to notify the proper officials.

**For health oversight activities:** We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline, or license those who work in the health care system or for government benefit programs.

**For activities related to death:** We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

**To avoid a serious threat to health or safety:** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to you or the public's health or safety.

**For military, national security, or incarceration/law enforcement custody.** If you are involved with the military, national security, or intelligence activities, you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

**To those involved with your care or payment of your care.** If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may release specific health information (your location and general condition) to those people. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. We may also release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency.

**Workers' Compensation.** We may disclose protected health information (PHI) as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

**Disclosures Required by HIPAA Privacy Rule.** We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting or certain disclosures of PHI about you.

**Incidental Disclosures.** We may use or disclose PHI incident to a use or disclosure permitted by HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

**Limited Data Set Disclosures.** We may use or disclose a limited data set (PHI that has certain identifying information removed) for the purposes of research, public health, or health care operations. This information may only be disclosed for research, public health, and health care operation purposes. The person receiving this information must sign an agreement to protect the information.

**NOTE:** Except for the situations listed above, we must obtain your written authorization for any other release of your health information. An authorization is different from consent, the primary difference is that unlike with consents, a provider must treat you even if you do not wish to sign an authorization form. If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to HIPAA Privacy Officer, Longest Student Health Center, P O Box 6338, Mississippi State, Mississippi 39762, 662-325-2431.

### **Your Health Information Rights**

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact, HIPAA Privacy Officer, Longest Student Health Center, P O Box 6338, Mississippi State, Mississippi 39762, 662-325-2431. Specifically, you have the right to:

**Inspect and copy your health information.** With few exceptions, you have the right to inspect and obtain a copy of your health information. For example, this does not apply to psychotherapy notes, or information compiled for judicial proceedings. We may charge a fee for a copy of your health information.

**Request to amend your health information.** If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make this request in writing and give a reason as to why the information should be changed. However, if we did not create the health information that you believe to be incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

**Request restrictions on certain uses and disclosures.** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or, you may wish to limit the health information provided to family or friends involved in your care or payment of medical bills. You may want to limit the health information provided to authorities involved with disaster relief efforts. We are not required to agree to a requested restriction.

If you receive certain medical devices (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purposes of tracking the medical device.

**As applicable, receive confidential communication of health information.** You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special private room or through a written letter sent to a private address. We must accommodate reasonable requests.

**Receive a record of disclosures of your health information.** In some instances, you have the right to ask for a list of the disclosures of your health information we have made for the previous six years, the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30 day extension, and we may not charge you for the list, unless you request such list more than once per year. Disclosures made to you do not include disclosures for purposes of treatment, payment, health care operations, national security, law enforcement/corrections, and certain health oversight activities.

**Obtain a paper copy of this notice.** You may request a paper copy of this notice at any time or view it at [www.health.msstate.edu/privacy](http://www.health.msstate.edu/privacy).

**Complain.** If you believe your privacy rights have been violated, you may file a complaint with us and with the Federal Department of Health and Human Services. We will not retaliate against you for filing a complaint. To file a complaint with either entity, please contact the **HIPAA Privacy Officer, Longest Student Health Center, P O Box 6338, Mississippi State, MS 39762, 662-325-2431, who will provide the necessary assistance and paperwork.** **This notice of medical information privacy is effective April 14, 2003.**

**Longest Student Health Center**  
**P O Box 6338, Mississippi State, Mississippi 39762**  
**Stanthia Oakley, Privacy Official**  
**662-325-0706**

### **Notice of Privacy Practices Receipt**

I acknowledge that I was provided with the HIPAA Notice of Provider Privacy Practices revision April 14, 2003 of Longest Student Health Center.

Print Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Patient's SSN/Chart Number: \_\_\_\_\_

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: \_\_\_\_\_

Describe Personal Representative Relationship: \_\_\_\_\_  
(parent, guardian, etc)

Signature of Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

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**For Practice Use Only**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Practice Employee

Date

Revision April 14, 2003