Campus Health Services
University of Louisville
Louisville, KY 40292

PATIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____
Last First M.I. Month Day Year

Maiden/Preferred/Other (circle one):_____ SEX: M __ F __ T___

Identify as (optional): _____ Preferred pronoun (optional): _____

Social Security Number: _____-_____-_____ Student or Employee ID #_____

Status: □ Undergraduate □ Graduate □ Staff □ Resident □ Faculty □ Other _____

Race:_____ Ethnicity: Hispanic____ Non-Hispanic____

Language Preference if other than English: _____ Translation Services Needed: Y or N

Local Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Permanent Address *(if different from local)* _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Preferred phone: (_____)_____ Email Address: _____ If we need to reach you by phone, may we leave a general health message? □ Yes □ No

Emergency Contact Name: _____ Emergency Contact Phone: (_____) _____

Preferred Pharmacy:_____ Pharmacy Phone Number:_____

INSURANCE

Primary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Phone Number (____) _____ Co-Pay Amount:_____

Insurance ID Number: _____ Group Number: _____

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Date of Birth: _____ Guarantor's Social Security Number: _____ - _____ - _____

Guarantor's Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Employer's Name:_____

Secondary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Phone number (____) _____ Co-Pay Amount:_____

Insurance ID Number: _____ Group Number: _____

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Date of Birth: _____ Guarantor's Social Security Number: _____ - _____ - _____

Guarantor's Address: _____ Apt. No.: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Employer's Name:_____

Do you have a living will? □ Yes □ No/ I don't know

Do you have a designated healthcare power of attorney? □ Yes, Who?_____ □ No/ I don't know

Health Services Office
University of Louisville
Louisville, KY 40292
Health Sciences Center Office (502) 852-6446
Belknap Campus (502) 852-6479

Consent for Medical Care and Release of Information

I wish to have treatment given to □ myself □ my child or □ ward by the University of Louisville Health Services Offices (hereafter known as "Health Services Office"). I hereby give □ myself □ my child's □ my ward's voluntarily consent to routine diagnostic and therapeutic procedures, such as physical exams, x-rays, vaccinations and laboratory tests. As the part of the care to be given, a test may be performed for human immunodefiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infections or communicable diseases if the doctor orders the test for DIAGNOSTIC purposes because of my/my child's/my ward's medical history, symptoms or clinical findings.

I fully understand that, as a courtesy to me, the Health Services Office will file my insurance claims. However, I am fully responsible for all bills incurred for services rendered. I will also be held responsible for all services not covered by insurance and payment is expected at the time of service. If payment is not received in a timely manner, I am aware that I may be turned over to a collection agency and reported to the credit bureau.

I hereby authorize the Health Services Office may share medical records and information with my health insurance carrier, as necessary to process insurance claims or payment for care provided. I further authorize payment of any health insurance benefits be made directly to the Health Service Office. I hereby acknowledge that I have read and fully understand the information set forth above and any questions have been answered to my satisfaction.

I hereby acknowledge that I have read and fully understand the Patient's Bill of Rights, which has been given to me.

Date: _____ Patient: _____

Date: _____ Witness: _____

Parents/Guardian Signatures

I hereby state that I am the □ parent □ legal guardian □ Other (specify: _____) of the patient and I am authorized to sign on their behalf.

Date: _____ Parent/Guardian: _____

Date: _____ Witness: _____

Campus Health Services
University of Louisville
Louisville, KY 40292

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

TO ACCEPT:

I acknowledge that I have been provided a copy of **Campus Health Services**' Notice of Privacy Practices:

_____ _____
Signature of Patient or Personal Representative Date

TO DECLINE:

I acknowledge that I declined **Campus Health Services'** Notice of Privacy Practices provided:

_____ _____
Signature of Patient or Personal Representative Date

University Medical Associates, University Surgical Associates, PSC, University Neurologists, PSC, University of Louisville Research Foundation Clinics, University Ob/Gyn Foundation, University Ob/Gyn Associates, University Psychiatric Services, University Psychiatric Associates, and University Physician Associates

Providing services as University of Louisville Physicians

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

SUMMARY

The confidentiality of your personal health information, commonly called your medical record, has always been a high priority for the nurses, doctors, dentists, staff and others involved in your healthcare at University of Louisville Physicians. There are a number of reasons that we may need to use this information or release (disclose) it to others. This Notice of Privacy Practices is provided to inform you of the ways that we can use and release information from your medical record**. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES, PLEASE READ THE ATTACHED DOCUMENT FOR ADDITIONAL INFORMATION.** In addition to the longstanding commitment of University of Louisville Physicians to protecting your information there are certain obligations that we have under federal law. One of those obligations is to provide you with this Notice

THINGS EXPLAINED IN THE NOTICE

How we may use and share your health information without your permission to:

- provide treatment to you,
- get paid for the services we provide to you
- operate our clinics and other facilities
- make reports to federal, state and local agencies and others when the law requires such reporting
- make reports or share health information for public health, safety and/or research reasons

How we can use and share your health information without your permission, but only if we give you chance to object:

- to share information about you to family, friends or others involved in your care or payment for the services you receive
- to share information about you in case of a disaster to let your family and friends know where you are and your general condition

How we can use and share your medical information only with your permission

What your legal rights are under federal privacy laws like your right to:

- Ask to see and copy your medical information.
- Ask that incorrect or incomplete information in your medical information by corrected
- Ask for a list of the places we have sent you information unless it was sent with your permission, for payment, treatment or health care operations
- Ask that we limit the information we use or share for payment treatment, payment or healthcare operations or the information we share with family members or others involved in your care or payment for your care. We are not required to agree to your request.
- Ask that we communicate with you in a confidential manner
- Ask for a paper copy of the Notice of Privacy Practices at any time

How you can file a complaint if you think your privacy rights have been violated

What our legal duties are regarding your medical information

Name: _____ DOB: _____ Date: _____

New/Interval Physical Visit

Drug and Material Allergies

Drug/Material	*Reaction*
□ No know medication /material allergies	

Current Medications

List all medications that you are currently taking on a regular or as needed basis. Also include any herbal, natural or other over the counter preparations

Medication/supplement	*Dose (mg)*	*Times per day*	*Indication/Reason*
□ No medications, herbal preparations or supplements			

Preventative Health

Do you/have you ever:

Smoked or chewed tobacco? □ Yes □ No

If yes, type: _____ amount per day: _____ Number of years: _____

Consumed alcohol? □ Yes □ No

If yes, how often: occasionally_____ daily (amount) _____ weekends (amount) _____

Used street drugs? □ Yes □ No

If yes, what type: _____ IV? □ Yes □ No

Abused prescription medications? □ Yes □ No

If yes, what type: _____

How many servings do you consume per day of: coffee_____ tea/sweet tea _____ soda_____ caffeinated? □ Yes □ No

How many servings of fruits and/or vegetables do you eat per day? 0-3_____ 4-6_____6-8_____ >8_____

Do you eat/consume dairy products? □ Yes □ No Servings per day: _____

Do you take a calcium supplement? □ Yes □ No With Vitamin D? □ Yes □ No

Do you:

Exercise regularly?

# of times per week_____for_____mins/hrs Type of activity (ies) _____

Wear your seatbelt? □ All of the time □ Most of the time □ Sometime

Wear a helmet when you bike or ride a motor cycle? □ All of time □ Most of the time □ Sometime

Have smoke detectors in your home? □ Yes □ No

Use sunscreen regularly? □ Yes □ No

Family Medical History

Please indicate if any blood relative has ever had any of the following. Check box and indicate which relative(s) and age of onset:

Disease	Relative	Age		Disease	Relative	Age
□ Alcohol or other drug abuse				□ High blood pressure		
□ Anxiety or panic attacks				□ High cholesterol		
□ Anorexia or bulimia				□ Kidney disease		
□ Bipolar and/or mania				□ Liver disease/hepatitis		
□ Bleeding disorder				□ Migraine headaches		
□ Breast cancer				□ Obsessive compulsive disorder		
□ Colon cancer				□ Stroke		
□ Depression				□ Suicide		
□ Diabetes				□ Tuberculosis		
□ Heart attacks				□ Other		

MD/ARNP:_____ Date:_____

Name: _____ DOB: _____ Date: _____

New/Interval Physical Visit

Past Medical History

Check all that apply. Use comment area for additional details or other disorders.

- □ Abnormal EKG
- □ Abnormal mammogram
- □ Abnormal PAP
- □ Allergies (seasonal/environmental)
- □ Anorexia and/or Bulimia
- □ Arthritis
- □ Asthma
- □ Anemia
- □ Anxiety
- □ Back injury
- □ Bi-polar disease or mania
- □ Broken Bones
- □ Breast cancer
- □ Cataracts
- □ Chest pain
- □ Crohns disease
- □ Colon cancer
- □ Constipation
- □ Depression
- □ Deep vein thrombosis/blood clots
- □ Dental or gum problems
- □ Diabetes Type:_____
- □ Diverticulosis/Diverticulitis
- □ Emphysema (COPD)
- □ Eye disease
- □ Gastroesophageal reflux
- □ Gallbladder problems/stones
- □ Head injury/concussion
- □ Hearing loss
- □ Headaches
- □ Heart attack
- □ Heart failure
- □ Heart murmur
- □ Hepatitis
- □ HIV/AIDS
- □ Hiatal (high) hernia
- □ High cholesterol
- □ High blood pressure
- □ Irritable bowel syndrome
- □ Kidney stones
- □ Pneumonia or "Bronchitis"
- □ Positive TB skin test
- □ Rheumatic fever
- □ Seizures
- □ Sinus problems/sinusitis
- □ Skin problems
- □ Stroke and/or TIA
- □ Transfusions (blood)
- □ Thyroid disease
- □ Ulcerative colitis
- □ Ulcers (stomach)
- □ Ulcers (legs & feet)
- □ Urinary tract/kidney infections
- □

Other Conditions/Hospitalizations/Surgeries/Operations and Dates:

_____

_____

_____

Social/Occupational History

Marital Status: □ Single □ Married □ Life Partner □ Divorced □ Living Together □ Separated □ Widowed

Student Status: □ Full-time □ Part-Time

Employment: □ Retired □ Employed □ Full-time □ Part-time □ Self-employed □ Homemaker □ Unemployed

Number of children?_____ Ages?_____

Who lives at home besides yourself?_____

Do any family members have significant healthcare or emotional needs?_____

What year are you in school?_____

Any hobbies or recreational activities?_____

Current Occupation:_____

Sexual Health

Have you ever been sexually active? □ Yes □ No Do you use condoms? □ Always □ Sometimes □Never

How many lifetime sexual partners have you had? _____

Have you had any new sexual partners within the last year? □ Yes □ No

Have you ever been TESTED for any sexually transmitted infection (STI or "STD")? □ Yes □ No

Have you ever had or been treated for any STI ("STD")? □ Yes □ No

Would you identify yourself as:

□ Heterosexual □ Gay/Lesbian □ Bisexual □Transsexual □ Unsure □ Prefer not to answer

Other sexual health issues/concerns:

_____

_____

MD/ARNP:_____ Date:_____

Name: _____ DOB: _____ Date: _____

New/Interval Physical Visit

Women's Health Information

Menstrual History

How old were you when your menstrual periods began? _____
Are you still having periods? □ Yes □ No
Date your last menstrual cycle started: _____
Do your periods typically come ever 4-6 weeks? □ Yes □ No
How many days do they last? _____
Age you first became sexually active? _____

PAP History

Have you had a PAP smear? □ Yes □ No
Date and location of last PAP: _____
Have you ever had a colposcopy/biopsy/freezing procedure? □ Yes □ No
If yes, when (year)? _____ Office/MD who did procedure: _____

Obstetric History

# of pregnancies _____ Deliveries: vaginal _____ c-section _____ miscarriages _____ terminations _____
Age at first delivery: _____ Age at last delivery: _____
Did you breast feed? □ Yes □ No If so, how long? _____

Contraception

Current method(s) _____
Previous method(s) _____Reason stopped/problems_____
_____

Other

Have you ever had a bone density (osteoporosis) test? □ Yes □ No If yes, when/where?_____
Have you had gynecological surgery? □ Yes □ No
Have you had your ovaries removed? □ Yes □ No Your uterus? □ Yes □ No
Do you/did you ever take estrogen (female hormones) after menopause? □ Yes □ No
Have you had a mammogram or breast ultrasound? □ Yes □ No If yes, when & where? _____

Immunizations

Please fill out the attached Immunization Record or sign medical record release for immunization records.

Review of Systems

	Norm	Abnorm		Norm	Abnorm	**Comments on abnormal/pertinent normals for physical exam and review of systems**
General			Renal			
Head			Endocrine			
Eyes			GU			
Ears			Skin			
Nose			Musculoskeletal			
Throat			Neuro			
Cardiac			Lymphatics			
Pulmonary			Sleep			
GI						
Other (describe)						

MD/ARNP:_____ Date:_____

UofL Campus Health Services
University of Louisville
Louisville, KY 40292

NOTICE OF PRIVACY PRACTICES
Effective Date: April 14, 2003

THIS NOTICE TELLS YOU HOW YOUR MEDICAL RECORD MAY BE USED
AND SHARED AND HOW YOU MAY GET THIS INFORMATION.

PLEASE READ IT CAREFULLY

OUR PLEDGE TO YOU

Your health information is something that the UofL Campus Health Services has always worked to keep private. We also are ethically and legally bound to keep it confidential under state and federal laws.

WHAT IS THIS DOCUMENT?

This document, called a Notice of Privacy Practices, tells you how we may use and share your health information. This includes using and sharing it so that we may provide you with health care and be paid for it, and so that we may run our business and follow state and federal legal rules. We must follow the terms of this notice.

WHO FOLLOWS THIS NOTICE

This notice is for Campus Health Services. Other separate health-care providers at the U of L Medical Center also may provide you with health services. You might receive a notice of privacy practices from them, too. If you are seen in a hospital at the U of L Medical Center, it will give you a notice that covers medical information gathered during your visit there including the information created by Campus Health Services.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WITHOUT YOUR PERMISSION.

Treatment: We will use and share your medical record for your care.

Example: Doctors, dentists, students, medical residents or other university workers may read your record to learn if a treatment is working. Your medical information also may be shared with doctors or dentists outside Campus Health Services to decide the best treatment for you.

Payment: We may use and share your medical information to be paid for the care and services we provided you.

Examples: We may contact your insurance company to learn if a service is covered. We may bill you or your insurance company for the services we provide.

Health-care Operations: We need to use and share your health information to run our health-care business. We may use or share your information for several reasons.

Examples: Our staff may use your medical information to make sure that you and other patients get the best possible care. Medical students may see the information as part of their training. Others on our staff may use it to make sure that billing is being done correctly. In certain special conditions, other health-care providers may get your information from us to run their businesses.

Business Associates: We may share your medical information with another company or organization, called a "business associate" that we hire to provide a service to us or on our behalf. We will only share your information if the business associate has agreed in writing to keep it private.

Example: A company that submits bills on our behalf to your insurance company.

Appointment Reminders: We may contact you to remind you of an appointment or to change one. We may also let you know that it is time for a follow-up appointment or a regular check-up.

Health-Related Benefits, Services and Treatment Alternatives: We may tell you about interesting health-related benefits or services such as newsletters, announcements, possible treatments or alternatives.

Assistance for special projects, services and research: Campus Health Services relies on the kindness of the community to help us provide quality health care to this region. *Patients who share their experiences and suggest ways to work with us are giving back in a meaningful way.* Their information also helps us improve and expand our services. We may use or share limited information, called demographic information, and the date you received care, to ask for your help. We also may share this information with our related foundation or business associates so they can contact you. Your generosity helps us continue to be an outstanding provider of health-care services in this region.

Required Disclosures: The Secretary of the Department of Health and Human Services may investigate privacy violations. If your health information is requested as part of an investigation, *we must share your information with the Secretary of the Department of Health and Human Services.* We will share your information if they ask for it as part of an investigation of a privacy violation. Under the same laws, we must give you information in your medical record. We are allowed to keep some information from you.

Required by Law: We must share medical information if federal, state or local law says so.

Public Health and Safety: We may share your medical information for public health reasons. These include:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report information to the FDA about the products it oversees;
- to let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition; or
- to your employer in certain limited instances.

Abuse and Neglect: The law may require us to report suspected abuse, neglect or domestic violence to state and federal agencies. Your information may be shared with these agencies for this purpose. Generally, you will be told that we are sharing this information with these agencies.

Health Oversight Activities: Certain health agencies are in charge of overseeing health-care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

Legal Proceedings: If a court or administrative authority orders us to do so, we may release your health records. We will only share the information required by the order. If we receive any other legal request, we may also release your health record. However, for other requests we will only release the information if we are told that you know about it, had a chance to object and did not.

Law Enforcement: We may share health information if a law enforcement official asks for it:

- to respond to a court order, warrant, summons or other similar process;
- to identify or locate a suspect, fugitive, material witness or missing person; or
- to obtain information about an actual or suspected victim of a crime.

We may share information with a law enforcement official:

- if we believe a death was the result of a crime;
- to report crimes on our property; or
- in an emergency.

Coroners, Medical Examiners and Funeral Directors: We may share health information with a coroner or medical examiner to identify a dead person or find the cause of death. We also may release health information to funeral directors if they need it to do their job.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to the organizations in charge of getting, transporting or transplanting an organ, eye or tissue.

Research: We may share your medical record with researchers, without your permission, in very limited situations. In most cases, a researcher must submit his/her request to see your information to a special group called the Institutional Review Board ("IRB"). This group will decide if it should allow the researcher to use or share your information. Your medical information also may be used by or shared with researchers to prepare for research, but only under strict conditions. Under similar strict conditions, medical information about dead people can be used or shared.

To Prevent a Serious Threat to Safety: We may use and share your medical information to prevent a serious threat to your health and safety or the health and safety of others.

Special Governmental Functions: We may share your medical information with:

Authorized federal officials

- for intelligence, counter-intelligence and other national security activities authorized by law; or
- to protect the president.

Armed forces command authorities or the Department of Veteran's Affairs

- to see if you are fit for military duty or eligible for veterans health services; or
- to see if you are medically fit to receive a security clearance by the Department of State.

Correctional facility or law enforcement official or agency if you are an inmate or under the custody of a law enforcement official or agency, if necessary, to:

- help the correctional facility provide you with health care; or
- protect the health and safety of you and/or others.

Workers Compensation: We may share your health information with agencies or individuals to follow workers compensation laws or other similar programs.

WAYS WE MAY USE AND SHARE YOUR HEALTH INFORMATION WHEN WE HAVE GIVEN YOU A CHANCE TO OBJECT.

Individuals Involved in Your Care or Payment for Your Care: We may share medical information about you with your family members, friend or any other person you tell us who is involved in your medical care or who helps pay for it.

We may tell your family or friends your condition and that you are in one of our facilities. We also may share medical information about you to a disaster relief agency so that your family can be told of your condition and location.

Usually you will have a chance to object to the sharing of this information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have certain rights regarding your health information, described below. These rights apply to the health information we keep. You must submit a written request to use any of these rights. You can send your written request to Campus Health Services at the address given at the end of this notice.

Right to Request Special Communications: You have the right to ask us to contact you about medical matters in a certain way or at a certain place. We will follow all reasonable requests. Your request must tell us how you wish to be contacted.

Right to Inspect and Copy: You have the right to read or get a copy of your health information, with some exceptions. We may turn down your request under certain circumstances. If we do so, you may ask for a licensed health-care professional chosen by us to review why we turned you down. We will follow the reviewer's decision.

Right to Request Changes: If you believe the health information that we created is wrong or incomplete, you may ask us to change it. *You must provide a reason why you want the change*. We cannot take out or destroy any information already in your medical record. We also are not required to agree to make the change. If we do not agree to the change, you can write a letter about the changes. We will send you one back saying why we will not make the changes. You may then send another disagreeing with us. It will be attached to the information you wanted changed or corrected.

Right to an Accounting of Disclosures: We are required to track who we share your health information with under certain circumstances. You have the right to ask for a copy of this list. We do not have to track every time we share your health information with others. *Your request must give a time period, which may not be longer than 6 years and may not include dates before April 14, 2003.*

Right to Request Restrictions: You have the right to ask for a restriction or limitation on the medical information we use or share about you for payment, treatment or health-care operations and the information we may share with your family, friends or others involved in your care. We are not required to agree to your request. If we agree, we will follow your request unless the information is needed to provide you with emergency treatment. You must tell us the type of restriction you want and to whom it applies.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. Copies of this notice will be posted and available at each location where medical services are provided and at **http://louisville.edu/campushealth/forms**

OTHER USES AND SHARING OF YOUR HEALTH INFORMATION

All other uses and sharing of your health information will be done only with your written permission.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have as well as any we get in the future. Any changes in this notice will be posted on our Web site at **http://louisville.edu/campushealth/forms.** The revised notice also will be available at any of the locations where Campus Health Services offers services.

WHAT IF I HAVE QUESTIONS OR NEED TO REPORT A PROBLEM?

If you have any questions about this notice or about how your health information is used or shared by us please contact the Campus Health Services 's Privacy Officer by e-mail at **privacyhso@louisville.edu** or by calling **852-6446**.

If you believe your privacy rights have been violated, you may file a complaint with us.

To file a complaint, please contact the **Campus Health Services**' Privacy Officer at

http://louisville.edu/campushealth/forms

or write to

Privacy Officer
HSC Health Office
401 East Chestnut Street Suite 110
Louisville, KY 40292.

Please give as much information as possible so that the complaint can be looked into properly.

You may also file a complaint with the Secretary of the Department of Health and Human Services.

Your care will not be affected if you file a complaint, nor will any action be taken against you.