Campus Health Services University of Louisville

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION			
Last Name:	**First:**	**Middle:**	**Social Security number:**
Preferred Name:	**Student/Employee ID #:**	**Birth Date:** _____/_____/_____	**Sex:** M ❑ F ❑ T ❑
Race:		**Ethnicity:** ❑ Hispanic ❑ Non-Hispanic	
Street address:			**Current Phone Number** (_____) _____ - _____
City:		**State:**	**ZIP Code:**

INSURANCE INFORMATION		
Subscriber's Name:		
Subscriber's Home Phone Number:		**Subscriber's Birth Date:** _____/_____/_____
Subscriber's Address (if different than above):		
Primary Insurance Company's name:	**Primary Insurance Company Phone Number:**	
Subscribers Employer:	**Policy Number**	**Group Number**

Additional insurance policy information may be requested by Campus Health Services

Campus Health Services
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 by the University of Louisville Campus Health Services Offices (hereafter known as "Health Services Office"). I hereby give 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 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 authorize the Health Services Office to provide any viral pathogens or Covid19 testing results to my employer.

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: _____

Submit Form