For Office Use Only
Chart #:
Account #:

APPLICATION

Weisskopf Center-University of Louisville

Novak Center for Children's Health

411 E Chestnut St. 2nd Floor, Louisville, KY 40202 Telephone: (502) 588-0850 Fax: (502) 588-9534

Patient's Information

Today's Date: _____ **Patient's Last Name:** _____ **First:** _____ **Middle:** _____

Birthdate: _____ Sex: _____M _____F Patient's Social Security Number: _____

Race: *For statistical purposes only, please provide the child's race*. This information will be kept confidential.

☐ Caucasian ☐ African-American ☐ Asian/Pacific ☐ Native American ☐ Hispanic ☐ Bi-Racial ☐ Unknown ☐ Other _____

Primary Language Spoken: _____ **Do you need/want an interpreter for your visit**? _____

Child's Residence: Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Other Phone: _____ Email Address: _____

Person Completing Application: _____ Relationship to Patient: _____

Child lives with: _____ Relationship to Patient: _____

Who will be responsible for the bill (guarantor)? _____ Relationship to Patient: _____

Are other siblings being referred at this time? If so, name(s), so we may coordinate services _____

Mother's Information

Mother's Name: Last: _____ First: _____ Middle: _____

Birth Date: _____ Years of Schooling: _____ Occupation: _____ Work Phone: _____

Father's Information

Father's Name: Last: _____ First: _____ Middle: _____

Birth Date: _____ Years of Schooling: _____ Occupation: _____ Work Phone: _____

Parent / Legal Guardian Information

Parents are: *(Check One):* ☐ Natural/Biological ☐ Foster ☐ Adoptive ☐ Other: _____

Birth Name of Child: _____

Parent's Marital Status: *(Check One):* ☐ Married (Years) ☐ Single ☐ Separated ☐ Widowed ☐ Divorced

Who is the child's legal guardian? _____

Legal Guardian's Address (if different from child's):_____

Telephone Number:_____ Email Address:_____

Emergency and Physician Information

Name of Emergency Contact: _____

Relationship: _____ Telephone: _____ Cell Phone: _____

My / My Child's Physician: _____ Street: _____

City _____ State: _____ Zip Code: _____ Telephone: _____

Referral Information

What have you been told about why you were referred to the Weisskopf Center?_____

_____

What current services is your child receiving to address these concerns? _____

_____

What is your goal for this evaluation? Why are you requesting this evaluation? _____

_____

Birth and Pertinent Medical History

(Disregard if seen at WCEC previously)

Birth Hospital Name: _____ Street: _____

City: _____State: _____ Zip Code: _____ County: _____

Child was: ☐ Full term ☐ Premature _____weeks Child's length of stay in the hospital? _____ (Circle One: Days Weeks)

Additional information: _____

Birth and/or Perinatal complications, if any? _____

Current Medications

Medication	Dose	Medication	Dose
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Pertinent Medical History

Date	Findings/Condition/Accident	Medical Provider	Street Address, City, State, Zip Code

Additional Services/Recent Care

Has your child's Hearing been tested?: ☐ No ☐ Yes, by _____

Address:_____

Has your child's Vision been tested?: ☐ No ☐ Yes, by _____

Address:_____

Is your child in First Steps?: ☐ No ☐ Yes, my Service Coordinator is _____

Address:_____

Current therapy if any:

☐ **Occupational Therapy** Agency & Therapist Name: _____

Address:_____

☐ **Psychological Services/Therapy** Agency & Therapist Name: _____

Address: _____

☐ **Speech/Language Therapy** Agency & Therapist Name: _____

Address: _____

☐ **Developmental Intervention** Agency & Therapist Name: _____

Address:_____

☐ **Other**_____ Agency & Therapist Name: _____

Address:_____

Additional Information

Please include additional information that could be helpful to our team:

_____

_____

_____

_____

_____

BILLING AND INSURANCE INFORMATION **WCEC APPLICATION**

Primary Insurance

Insurance Name	Insurance Phone
Insurance Address	
Policy Holder's Name	Policy Holder's Social Security Number
Policy Holder's Date of Birth	Policy Holder's Insurance ID Number

Secondary Insurance

Insurance Name	Insurance Phone
Insurance Address	
Policy Holder's Name	Policy Holder's Social Security Number
Policy Holder's Date of Birth	Policy Holder's Insurance ID Number

The patient has *(Check one)*: **Passport** ☐ **Kentucky Medicaid** ☐

Patient's Name as it Appears on ID Card	Effective Date
Patient Passport/Medicaid ID Number	Patient Date of Birth
Primary Care Physician's Name	PCP's Telephone
PCP's Address	
Date patient last saw PCP	

Please provide our Center with copies of all medical insurance cards. Even if the patient has Passport or Medicaid, we must still have copies of any other medical insurance on the patient. Please verify with your insurance company if you need prior authorization for services. It is your responsibility to meet your insurance company's requirements for reimbursement.

I certify that the above information furnished by me is true and correct.

_____ _____

Signature Date

GENERAL REQUEST FOR RELEASE OF MEDICAL RECORDS

To be used for release of information to the patient, whoever the patient designates release to, or to a provider of their choice; or to request the patient's records from another provider.

In order to release your/the patient's records, you must sign a request for release. This form must include the patient's name and date of birth. It is your responsibility to read this form in full and to ask any questions before the record is released. No phone call requests will be honored.

Designate Who You Want To Release Your Records:

University of Louisville (UofL) Release Your Records

The following information explains our policy for releasing protected health information:

- Medical records will be released only to the patient or to whoever the patient designates them to be released to.
- Law office/attorney medical records requests must have valid patient authorization with the request.
- Please be prepared to show ID when picking up records in person. This is for the protection of your personal health information.
- Patient's legal representatives must provide appropriate documentation to demonstrate their legal status.
- HIV, STD, substance abuse, and psychiatric records are not released without specific separate authorization.
- Please allow up to 30 days for records stored off site; however, UofL may take up to 60 days to process the request, if necessary.
- First copy provided free of charge.

Release Records to (provide information below): ☐ Patient's Designee ■ Provider Office

Name **Weisskopf Center** Phone **(502) 588-0907** Fax **(502) 588-9534**

Address 411 E Chestnut St. Ste 295 Louisville KY 40202
Street City State Zip

Birth Hospital Release Your Records To UofL

Hospital Name _____ Phone _____

Hospital Address _____
Street City State Zip

Patient Information, Signature, and Records Being Released:

_____ _____
Patient's Name (Please Print) Date of Birth

×_____ ×_____
Patient/Parent/Legal Guardian Signature Date

If Parent/Legal Guardian, Print Name _____

Records Being Released : Date Range From _____ To _____

☐ Entire Chart ☐ Labs ☐ Office Notes ☐ Other (Specify Below)

_____

Do Not Write Below This Line – For Office Use Only

UofL Practice Site (optional) _____

Phone _____ Fax _____

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Release Records to (provide information below): ☐ Patient's Designee ■ Provider Office

Name **Weisskopf Center** Phone **(502) 588-0907** Fax **(502) 588-9534**

Address **411 E Chestnut St. Ste 295** **Louisville** **KY** **40202**
Street City State Zip

Primary Care Doctor Release Your Records To UofL

Provider Name _____ Phone _____

Provider Address _____
Street City State Zip

Patient Information, Signature, and Records Being Released:

_____ _____
Patient's Name (Please Print) Date of Birth

×_____ ×_____
Patient/Parent/Legal Guardian Signature Date

If Parent/Legal Guardian, Print Name _____

Records Being Released : Date Range From _____ To _____

☐ Problem List ☐ Growth Chart ☐ Diagnostic Testing ☐ Labs ☐ Consult Notes

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UofL Practice Site (optional) _____

Phone _____ Fax _____