

*Upper Cumberland Urology Associates, P.C.*  
*Patient Registration Sheet*

Today's Date \_\_\_\_\_

You Are Here To See:  Dr. Womack     Dr. Moore     Dr. Cancel     Connie Whitesell, N.P.  
(Please check one)

Patient's Full Legal Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Language \_\_\_\_\_ Ethnicity \_\_\_\_\_

IS PATIENT IN A NURSING HOME?  NO  YES IF YES, CHECK ONE →

<input type="checkbox"/>	BETHESDA
<input type="checkbox"/>	NHC
<input type="checkbox"/>	MASTERS
<input type="checkbox"/>	CLAY CO
<input type="checkbox"/>	OTHER:
<input type="checkbox"/>	_____

Patient's Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient's Home E-Mail Address: \_\_\_\_\_

Patient's Place of Employment (name and city) \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_

Souse's Name \_\_\_\_\_ Spouse's DOB \_\_\_\_\_

Spouse's Place of Employment (name and city) \_\_\_\_\_  
(Name and city)

How were you referred to us?

- |   |  |
|---|--|
| <input type="checkbox"/> FAMILY PHYSICIAN       | <input type="checkbox"/> DOCTOR SEMINAR                        |
| <input type="checkbox"/> RELATIVE OR FRIEND     | <input type="checkbox"/> NURSE PRACTITIONER SEMINAR            |
| <input type="checkbox"/> YELLOW PAGES           | <input type="checkbox"/> HEALTH FAIR                           |
| <input type="checkbox"/> NEWSPAPER              | <input type="checkbox"/> MAILING FROM UPPER CUMBERLAND UROLOGY |
| <input type="checkbox"/> UCUROLOGY.COM WEBSITE  |  |
| <input type="checkbox"/> OTHER (Specify): _____ |  |

Name and Phone Number of Relative or Other Emergency Contact Person:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

**SUBSCRIBER/MEMBER INFORMATION**

INSURANCE COMPANY	NAME	BIRTHDATE	SOCIAL SECURITY #	SEX
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

\*\*\*WE NEED TO MAKE COPIES OF ALL YOUR INSURANCE CARDS\*\*\*

*Please sign to confirm you have been offered a copy of Upper Cumberland Urology Associates, P.C. privacy notice.*

\_\_\_\_\_

*Upper Cumberland Urology Associates, P.C.*

**I. PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:**

I authorize UCUA to discuss my medical record with the following people: \_\_\_\_\_  
\_\_\_\_\_

I hereby give my consent for UCUA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Note: UCUA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. UCUA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Upper Cumberland Urology Associates, Privacy Officer, 320 North Oak, Cookeville, TN 38501.

With this consent, UCUA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, UCUA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among other items. UCUA may, upon receiving requests regarding the above information, may give out that information after verifying the identity of the requestor.

I have the right to request that UCUA restrict how it uses or discloses my PHI to carry out TPO by completing a Request for Limitation or Restriction of PHI form. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to UCUA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, UCUA may decline to provide treatment to me.

**II. PATIENT CONSENT TO TREATMENT:**

I consent to medical treatment and diagnostic procedures provided by the physicians and/or employees of UCUA.

**III. ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL GUARANTY:**

I authorize payment of insurance benefits to UCUA. In exchange for services given to the patient, I agree that I am responsible for the payment of the account, unless another guarantor is named on the Patient Registration Sheet.

**IV. PATIENT CONSENT FOR OBTAINING MEDICATION HISTORY**

I hereby authorize UCUA to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Legal Representative's Name