

Center for Urological Treatment

Registration

Patient Name _____ Date of Birth _____ Age _____

Address _____

City, State, Zip Code _____

Home Phone # _____ Cell Phone # _____

Social Security # _____ Sex: Male Female

Employer _____ Work Phone # _____

Marital Status: S D M W Parent/Spouse: _____

Parent/Spouse Employer: _____

Who may we contact in case of emergency? _____ Phone Number _____

Please present your insurance card at the time of service.

I hereby authorize Center for Urological Treatment to release any information acquired in the course of my examination or treatment and permit payment directly to them any benefits due for their services rendered. I also authorize the Center for Urological Treatment (any physician or employee) to obtain any outside medical or radiological information from any facility or physician considered necessary in managing my care. I recognized and accept financial responsibility for Services rendered. This includes but is not limited to co-insurance, co-payment, deductible, and non-covered services. Acknowledged, assigned directed and executed on:

Date _____

Signature _____

Privacy and Disclosure of Protected Health Information Notice

I have received, read and understand the Privacy and Disclosure of Protected Health Information Notice from the Center for Urological Treatment. I understand that this form notifies me of when and how my protected health information will be used and disclosed. I furthermore agree with the information as set forth in said document. I understand that if I ever want to change my mind and make adjustments, I may do so by notifying, in writing, Lori Ray, 345 23rd Avenue North, Suite 212, Nashville, TN 37203.

May we leave you a message at home? _____ May we leave you a message at work? _____

Signature _____ Date _____

History and Physical

Patient Name _____ Patient Date of Birth _____

Primary Care Physician _____ Phone # _____

Referring Physician _____ Phone # _____