

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 # _____

Center for Urological Treatment

**345 23rd Avenue North, Suite 212
Nashville, TN 37203
Ph 615 327-2055 Fax 615 329-4005**

**Dean Knoll, M.D.
Frank Lohrasbi, M.D.
Mitchell Wiatrak, M.D.
Tara Allen, M.D.
Howard Aubert, M.D.**

Satellite Offices:

**Ashland City Location
313 North Main Street
Ashland City, TN 37015
Ph (615) 792-0318**

**Dickson Location
127 Crestview Drive, Suite 207
Dickson, TN 37055
Ph (615)441-4484**

**Bowling Green KY Location
1327 Andrea Street, Suite 103
Bowling Green, KY 42104
Ph (270) 393-9505**

I, the undersigned, hereby assign to the Center for Urologic Treatment any and all rights and payable benefits that I may have under any policy of health insurance.

I agree to pay any charges considered non-covered or not payable, regardless of any HMO, PPO or any other health organization's coverage policies in which the Center for Urologic Treatment is "NOT" a participating provider. I am aware that my insurance coverage may not cover the expenses of my diagnosis and/or surgical charges and that I am fully responsible for all charges incurred from medical treatment rendered. I also understand that some HMO insurance policies require a referral and this referral is my (the patient) responsibility. If a referral is not received from the primary care physician, my insurance will not cover the expenses for medical treatment rendered and I will be responsible for the charges.

I also hereby authorize the Center for Urological Treatment to release whatever medical information necessary to complete the processing of any claims filed with any insurance policy that I may have.

I understand that the physicians of the Center for Urological Treatment have helped to establish Centennial Surgery Center and have an ownership interest in the Center; this Center is a provider of outpatient surgical services. As well, should ESWL (extracorporeal shock wave lithotripsy; i.e. "lithotripsy") services be utilized, physicians of the Center for Urological treatment have interest in Western Kentucky Lithotripter who provide the machine used for this procedure. I also understand there are other providers of outpatient surgical care, which I may choose to use. A list of other providers will be made available to me at my request.

I also understand that cancellations must be made within 24 hours of any scheduled appointment or surgery. A fee of \$30.00 for return appointments and \$50.00 if a procedure/surgery is scheduled will be charged for all missed appointments.

My signature below indicates I have read and understand the above statements.

Patient Signature

Printed Name

Date