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

Today's Date _____

You Are Here To See: ☐ 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 →

☐ BETHESDA
☐ NHC
☐ SIGNATURE
☐ CLAY CO
☐ OTHER:
_____

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 # _____

Spouse's Name _____ Spouse's DOB _____

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

How were you referred to us?

____ FAMILY PHYSICIAN
____ RELATIVE OR FRIEND
____ YELLOW PAGES
____ NEWSPAPER
____ UCUROLOGY.COM WEBSITE
____ DOCTOR SEMINAR
____ NURSE PRACTITIONER SEMINAR
____ HEALTH FAIR
____ MAILING FROM UPPER CUMBERLAND UROLOGY
____ Local TV Channel
____ OTHER (Specify): _____

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

Name _____ Phone Number_____ Relationship _____

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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.

_____

Rev. 11/28/18 KK

Upper Cumberland Urology Associates, PC
PATIENT FINANCIAL POLICY

Thank you for choosing Upper Cumberland Urology Associates as your urology office. The following is a statement of our Financial Policy, which we require you sign prior to any treatment. We ask that all patients read and sign prior to seeing the Provider.

We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and timely resolve any outstanding balances.

Insurance: Insurance coverage is a contract between you and your insurance company. Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by your insurance. If the insurance company has not processed and paid the claim within 90 days, then payment of the account will become the responsibility of the patient or legal guardian.

Demographic Information & Insurance Cards: It is extremely important that we have updated demographic data so that we will be able to contact you in the future. We also must have a current copy of your insurance card and a photo ID on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refilled to a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for timely filing you your insurance and those claims would become your financial responsibility.

Network Providers: It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify and contact our Business Office, if there is any question regarding network eligibility.

Co-pays, Co-Insurances & Deductibles: **I understand that any co-payments, deductibles and co-insurances are due from me at the time of service. I understand that I am responsible for any balance not covered by my insurance. We are required by Medicare/Medicaid to collect all co-insurances, co-pays and deductibles.**

Non-covered Services: It is possible that your insurance may not cover certain procedures or treatment for certain diagnoses. Please be aware that you will be responsible for any non-covered services.

Returned Checks: I understand that I will be charged and additional fee of $20.00 for any returned check.

Payment: We accept Cash, Check, Money Orders, MasterCard, Visa, American Express, Discover and Debit Cards for payment. You may be contacted by our office at any of your contact numbers listed to attempt to resolve any outstanding balances. In the event that the account is not resolved, I understand than my account may be turned over to a collection agency.

No Show: We understand that situations arise in which you must cancel your appointment. Patients who do not call and cancel their appointment within 24 hours of the scheduled appointment will be considered a **No show and will be subject to a $25.00 fee.** Our practice firmly believes that good physician/patient relationship is based on understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department.

Outside Lab Services: For labs not performed by our staff, we may utilize and outside lab company. Charges for these services are not controlled by Upper Cumberland Urology Associates. Patients are responsible for knowing whether their insurance plan covers laboratory services and for making arrangement for payment with the servicing lab.

Signature of Responsible Party	Relationship to Patient	Date

Patient Names(s): _____

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.

V. PATIENT CONSENT TO CALL

I hereby authorize consent to receive automated calls from UCUA regarding appointments, test results and billing from our practice via your home or mobile number.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Print Patient's Name | Print Legal Representative's Name

Upper Cumberland Urology Associates, P.C.
Health History Form

Chart #:_____ **Patient Name:** _____ **Date:** _____

Reason for visit: _____

Pharmacies

Primary: _____ Secondary: _____

Patient Care Team

Primary Care: _____ Referring Provider: _____

Oncologist: _____ Cardiologist: _____

Pulmonologist: _____ Other: _____

Height: _____ **Weight:** _____

Allergies

_____ _____

_____ _____

_____ _____

Medications and dosage **(Prescribed and over the counter meds, or a list may be given to the front desk):**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Last Flu Shot: _____ Last Pneumonia Shot: _____

Family History

Cancer : **YES NO**
If yes, the type and who : _____

High Blood Pressure: **YES NO**
If yes, who: _____

Stroke: **YES NO**
If yes, who: _____

Diabetes: **YES NO**
If yes, who: _____

Heart disease: **YES NO**
If yes, who: _____

Other: _____

Age of death: Mother: _____ Father: _____

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Social History

Do you smoke or use Tobacco? **YES NO**

If yes, how much: _____ Years of use:_____ Has smoked since age:_____

Are you currently employed? **YES NO** Occupation: _____

Marital status: _____ Number of children:_____

Do you consume Alcohol? **YES NO** Alcohol intake: _____

Do you have a history of substance abuse? **YES NO**

Do you experience urinary leakage or difficulty making to the restroom? **YES NO**

Are you deaf or have serious difficulty hearing? **YES NO**

Are you blind or have serious difficulty seeing? **YES NO**

Do you have difficulty concentrating, remembering or making decisions? **YES NO**

Do you experience difficulty walking or climbing stairs? **YES NO**

Do you have difficulty dressing or bathing? **YES NO**

Do you have difficulty doing errands alone? **YES NO**

Surgical History

Surgery/Side	*Year*	*Surgery/Side*	*Year*	*Surgery/Side*	*Year*
Appendectomy	_____	Colonoscopy	_____	Hysterectomy	_____
Back Surgery	_____	Gallbladder	_____	Knee Surgery **R L**	_____
Bladder Surgery	_____	Heart Surgery	_____	Sinus Surgery	_____
Breast Surgery	_____	Hernia Repair **R L**	_____	Tonsillectomy	_____
Cataract **R L**	_____	Hip Surgery **R L**	_____		

Other surgeries: _____

Past Medical History

Asthma	**YES NO**	Diabetes	**YES NO**	Liver Disease	**YES NO**
Arthritis	**YES NO**	Drug/Alcohol Abuse	**YES NO**	Multiple Sclerosis	**YES NO**
Atrial Fibrillation	**YES NO**	DVT w/Pulm. Emb.	**YES NO**	Nausea	**YES NO**
BPH	**YES NO**	Fibromyalgia	**YES NO**	Other Neurological Prob	**YES NO**
Bronchitis	**YES NO**	GERD/Reflux	**YES NO**	Pain	**YES NO**
Cancer	**YES NO**	High Cholesterol	**YES NO**	Parkinson's Disease	**YES NO**
Chest Pain	**YES NO**	Hypertension	**YES NO**	Psychiatric Disorder	**YES NO**
COPD	**YES NO**	Hypothyroidism	**YES NO**	Seizure Disorder	**YES NO**
Coronary Artery Disease	**YES NO**	Kidney Insuff/Failure	**YES NO**	Stroke	**YES NO**
Depression	**YES NO**	Kidney Stones	**YES NO**	Vomiting	**YES NO**

Have you ever had TB (Turberculosis)? **YES NO**
Have you been living with anyone in the past 2 years that has been diagnosed with TB? **YES NO**
Have you had a persistent cough and fever for more than 2 weeks? **YES NO**
Have you had a persistent cough and night sweats for more than 2 weeks? **YES NO**
Have you had a persistent cough and loss of appetite for more than 2 weeks? **YES NO**
Have you been coughing up or spitting up bloody sputum (saliva)? **YES NO**