LECONTE WOMEN'S HEALTHCARE
Covenant HEALTH

We Would Like to Thank You for Choosing
Leconte Women's Healthcare
for Your Health Care Needs.

PATIENT REGISTRATION

			Patient ID:
Last Name:	First Name:	MI:	Race/Ethnicity: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined
Nickname:	Maiden Name:		
Date of Birth:	Social Security:		Preferred Language:
Spouse Name:			
Residential Address:			Preferred Phone: [ ]Home [ ]Cell Home Phone:
City:	State:	Zip:	Cell Phone:
Billing Address Different? Yes No	Employer:		Work Phone:
Emergency Contact:	Relationship to Patient:		Phone Number:
Emergency Contact *(not living with you*):	Relationship to Patient:		Phone Number:

INSURANCE INFORMATION

Primary Insurance:	Policyholder's Name:	
Relationship to Patient: *[ ]Self [ ]Spouse [ ]Child/Parent [ ]Other*	Policyholder's Social Security No:	
Member ID#:	Group #	Policyholder's Date of Birth:

Secondary Insurance:	Policyholder's Name:	
Relationship to Patient: *[ ]Self [ ]Spouse [ ]Child/Parent [ ]Other*	Policyholder's Social Security No:	
Member ID#:	Group #	Policyholder's Date of Birth:

I hearby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described, realizing I am responsible to pay non-covered services. I understand that if my account is turned over to a collection agency, I will be responsible for any applicable fees. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Patient Signature: _____ Date: _____

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DISCLOSURE CONSENT

I can ask for and receive a copy of the Notice of Privacy Practices for this office upon request.

We are committed to providing an office environment that is professional, caring, and respectful of your time and privacy. The following agreement outlines communication information and office policies that are important in providing you with the best care.

I understand that it may/will be necessary to contact me with test results, billing questions, information about referrals to other offices, or to obtain medical information which may be needed to provide appropriate care.

What telephone number do you want us to call? _____

May we leave messages on *your* voice mail or answering machine?

YES ☐ NO ☐ N/A ☐

Is there anyone other than yourself we can speak to or leave messages with?

YES ☐ NO ☐ **If *YES* :**

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

Electronic (EMAIL) Communication: _____@_____

EMAIL : YES ☐ NO ☐ PORTAL: YES ☐ OPT OUT ☐

I understand FSWS & FSPNC may need to disclose my protected healthcare and personal information to another entity (referring doctors, primary-care doctors, pharmacies, making referrals, your insurance company) and I consent to disclosure for these permitted uses, by fax or telephone.

Referring Doctor: _____ **Phone:** _____

Primary Care Doctor: _____ **Phone:** _____

PATIENT & GUEST AGREEMENT:

NO FOOD OR DRINKS are to be brought into our waiting rooms or exam rooms. Please eat or drink all food items before entering our suite.

Due to **LIMITED SPACE** in our office we can only allow **2 people**, including children, back with you during your appointment. If you are having an ultrasound, we allow 2 people to switch out half way through the ultrasound so other family members may be included.

CELL PHONES: Please TURN OFF/SILENCE all cell phones while in our office. NO PHOTOGRAPHS are to be taken out of respect for the privacy of other patients.

I have read the agreements above and understand. I can ask for and receive a copy of this notice for my records.

_____

Patient Signature Date

_____

Signature of Guardian if Patient is a Minor Date Patient ID _____

Revised 9/4/2019