We would like to thank you for choosing
LeConte Women's Healthcare
for your healthcare needs.

Covenant HEALTH
LeConte Women's Healthcare Associates

UPDATE PATIENT REGISTRATION

Patient ID:	

Last Name:	First Name:	Middle:	Date of Birth:

Residential Address:	City:	State:	Zip:

Important: Please complete a new **Text, Email, Portal Consent** and **Disclosure Consent** if your telephone number(s) changes. The new form will replace all previous forms.

Home Phone:	Cell Phone:	Work Phone:	Preferred Phone: ☐ Home ☐ Cell

Spouse	Preferred Language

Emergency Contact:	Relationship to Patient:	Phone Number:

INSURANCE INFORMATION

Primary Insurance:	Policyholder Name:	

Member ID#:	Group#	Policyholder Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Child ☐ Other	Policyholder Gender: ☐ Male ☐ Female	Policyholder Phone Number:

Secondary Insurance:	Policyholder Name:	

Member ID#:	Group#	Policyholder Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Child ☐ Other	Policyholder Gender: ☐ Male ☐ Female	Policyholder Phone Number:

I hereby 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.

Legal representative signature required if patient is a minor or a representative has been appointed.

Patient / Legal Representative Signature _____ Date _____

Legal Representative Printed Name _____ Relationship to Patient _____

DISCLOSURE CONSENT

Covenant HEALTH
LeConte Women's Healthcare Associates

To provide you with the most timely updates regarding your care and test results, please provide your best contact numbers below, and notify us of any changes to your contact information so there are no delays in our communication with you.

Patient Last Name	First Name	Middle Name	Date of Birth

Enter preferred phone number(s) and mark Yes or No for each question; enter No if not applicable

Preferred Phone Numbers	Voicemail is set up for this phone number	Practice is authorized to leave detailed messages that may contain Protected Health Information (PHI)	Practice is authorized to leave messages with contact info only, e.g., practice name, caller, phone number
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Important Phone Tips: We ask that you answer all calls from Covenant Health to avoid missing important medical updates. Please ensure voicemail is set up and has space available so we can leave detailed information for you if we miss you. If you miss our call, please check voicemail before calling back, as we often leave the specific information you need in the message.

List information below for those to whom you authorize our practice to release/discuss your protected Health Information (PHI).

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Patient and 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 two (2) people, including children, back with you during your appointment. If you are having an ultrasound, we allow two (2) people to switch out halfway through the ultrasound so other family members may be included. 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.

By signing below I authorize release of my **Protected Health Information (PHI)** to individuals listed above and understand I may rescind authorization by completing a new form. I also acknowledge receipt and understanding of the **Patient and Guest Agreement** and will request copy of policy if one is needed.

Legal representative signature required if patient is a minor or a representative has been appointed.

_____ _____
Patient / Legal Representative Signature Date

_____ _____
Legal Representative Printed Name, if applicable Relationship to Patient

Fort Sanders Perinatal Center
LeConte Women's Healthcare

Fort Sanders Women's Specialists
Cumberland Women's Healthcare

Consent Form
Texts, Emails and Patient Portal

If you are not the patient, you must provide proof of your relation to the patient or other legal authority to receive communication

Our practice has the ability to send email and text messages to remind patients of upcoming appointments and provide other information about access to services.

Consent to Text and Email Communications. By signing below, I authorize this office to send text messages to the cell phone number listed below and/or e-mails to the address listed below to p*rovide information regarding appointments and other health-related communications related to my services at this office.

Security Advisement. I understand that email and text messaging are not secure forms of communication and information contained in emails or text messages sent to the address or number I have provided could be intercepted, accessed, or used by unauthorized third parties. I further understand that a wireless carrier may charge for text messages and that these messages may come from an automated dialing system.

Opt Out and Number Changes. I also understand that I may revoke this consent at any time by contacting this office at the number listed below. I further agree that in the event this cell phone number or cell provider changes, I will inform this office.

Fort Sanders Perinatal Center	**865-331-2020**	Fort Sanders Women's Specialists	**865-331-1122**
LeConte Women's Healthcare	**865-908-9888**	Fort Sanders Women's Specialists-Blount	**865-681-0103**
Cumberland Women's Healthcare	**931-459-7911**	Fort Sanders Women's Specialists-Hamblen	**423-492-7100**

Please complete each section below.

Text Messages

☐ **OPT IN** I would like to receive text messages at the cell phone number listed below and will inform this office if that number changes

☐ **OPT OUT** I do not wish to receive text messages from this practice. I understand I may change my election by completing a new form.

Email Messages

☐ **OPT IN** I would like to receive email messages at the address listed below and will inform this office if the email address changes.

☐ **OPT OUT** I do not wish to receive email messages from this practice. I understand I may change my election by completing a new form.

Patient Portal

☐ **OPT IN** I would like to participate in the Patient Portal. I realize I will receive an **email invitation** with the **PIN** required to activate my portal account at the email address listed below.

☐ **OPT OUT** I do not wish to participate in the patient portal. I understand I may participate in the future by completing a new form.

Patient Name _____ Date of Birth _____

Cell Phone _____ Email Address _____

Legal Representative signature required if patient is a minor or representative has been appointed

Patient / Legal Representative Signature _____ Date _____ Legal Representative Printed Name _____

Staff Signature _____ Date _____

Fort Sanders Perinatal Center
LeConte Women's Healthcare

Fort Sanders Women's Specialists
Cumberland Women's Healthcare

FINANCIAL AGREEMENT

We are happy that you have chosen us to provide your medical care. Our primary goal is to furnish your medical needs in a caring and competent manner. We do realize that medical care is expensive. Fortunately, most patients do have medical insurance to assist them in paying bills that accrue at our office. We will, as a courtesy, file the patient's visit with the insurance company as long as the patient has provided us with proper insurance information.

1. For GYN visits and office procedures, our office expects payment at the time services are rendered. The patient's **copay, estimate and prior balance are due at check in**, before services are rendered.

2. **For all maternity / obstetrical services**, our office expects payment at the time services are rendered. We will file patient visits with the insurance company. NOTE: If the insurance company has a percentage-based amount for the patient to pay, our office will assist in setting up payment arrangements for the amount due to be paid by the patient in advance of the estimated delivery date.

3. **SURGERY FEES:** Our office will provide the patient with an estimate of the physician fee. We will determine the amount not covered by the insurance company. This amount is what the patient will be held responsible for. Our office does require that the patient prepay in advance for any surgical procedures, all copayments, deductibles, co-insurance, or any other amount not covered by your insurance at least fourteen (14) days prior to your surgery date. After the surgery has been performed, our office will file the insurance claim for the patient.

4. All insurances that require a referral must have the referral completed before receiving treatment of any kind. Failure to obtain the referral prior to treatment may result in the patient being held responsible for the full amount owed for any medical treatment.

5. Finances are rarely discussed with the physician or other clinician. Any questions regarding finances or about the patient's account balance should be directed to a member of our office staff.

   Our billing office can be reached at **(865) 331-1982**.

6. Any outstanding account balance with our office will require a payment upon every visit to our office. Any outstanding account balance over 90 days may be turned over to a collection agency unless the patient or Legal Representative has spoken with a member of our billing department and made financial arrangements. Some obstetrical appointments may be rescheduled until such time as account balances are paid.

7. **In the event of a returned check for insufficient funds, or any other reason for denial, your account will be charged with a $25 account handling fee.**

Legal Representative signature and contact information are required if patient is a minor or representative has been appointed

Patient / Legal Representative Signature _____ Date _____

Legal Representative Printed Name _____ Relationship, if applicable _____ Phone Number _____

Street Address _____

City _____ State _____ ZIP Code _____

Patient ID _____

Revised 1/1/2026