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

Covenant HEALTH
LeConte Women's Healthcare Associates

PATIENT REGISTRATION

Last Name:	First Name:	Middle:	Patient ID:
Nickname:	Maiden Name:		Ethnicity: ☐ Declined ☐ Unknown ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Date of Birth:	Social Security Number:		Race: ☐ Black/AfricanAmerican ☐ White ☐ Asian ☐ Declined ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
Spouse Name:			Preferred Language:
Residential Address:			Home Phone:
City:	State:	Zip:	Cell Phone:
Billing Address (list below if different from Residental Address)			Work Phone:
			Preferred Phone: ☐ Home ☐ Cell
Guarantor Name: (list only if not patient)	Date of Birth:	Guarantor Address and Phone:	

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:

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:

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.

Patient / Legal Representative Signature*

Date

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

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

Fort Sanders Perinatal Center
LeConte Women's Healthcare

Fort Sanders Women's Specialists
Cumberland Women's Healthcare

Acknowledgement of Notice of Privacy Practices
Reconocimiento de aviso de prácticas de privacidad

Patient Last Name
Apellido del paciente _____

First Name
Nombre _____ Middle Name
Segundo nombre _____

Date of Birth
Fecha de nacimiento _____
(mes/dia/ año)

I acknowledge I have reviewed the NOTICE OF PRIVACY PRACTICES (NPP) for Fort Sanders Perinatal Center and its associated practices – Fort Sanders Women's Specialists, LeConte Women's Healthcare and Cumberland Women's Healthcare and understand I may request a printed copy of the Notice of Privacy Practices at any time.

If the patient is a minor or a representative has been appointed, Legal Representative signature and information are required below.

Reconozco haber revisado el Aviso de Prácticas de Privacidad (NPP) del Fort Sanders Perinatal Center y sus consultorios asociados: Fort Sanders Women's Specialists, LeConte Women's Healthcare y Cumberland Women's Healthcare, y entiendo que puedo solicitar una copia impresa del Aviso de Prácticas de Privacidad en cualquier momento.

Si el paciente es menor de edad o se le ha designado un representante legal, se requiere la firma y los datos del representante legal a continuación.

Patient/Legal Representative Signature
Firma del paciente / representante legal _____

Date / Fecha _____
(mes/día/año)

If applicable / si corresponde,

Legal Representative Name
Nombre del representante legal _____

Relationship to Patient
Nombre del representante legal _____

IN CONSIDERATION OF HEALTH CARE PROVIDER FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT (INFORMED CONSENT):

(a) *Treatment.* Patient, or Patient's Legally Authorized Representative (herein after collectively referred to as "Patient"), voluntarily authorizes and consents to Health Care Provider furnishing medical treatment and services to Patient, including medical treatment and services furnished through telehealth visits and e-consults, and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by Health Care Provider, its professionals, and their assistants and designees, including pharmacists and other professionals who are part of the healthcare team. Patient acknowledges and agrees treatment by Health Care Provider also may be furnished by a resident physician (a medical school graduate supervised by a physician).
(b) *Video/Photos for Medical Treatment Purposes*. Patient consents to the photographic or video documentation of medical treatment as permitted by Patient's treating Health Care Provider. Patient acknowledges and agrees that Health Care Provider will retain ownership rights to these recordings/images and that same will be stored in a secure manner to protect Patient's privacy. Patient understands and agrees that those recordings/images will be kept for the period required by law or Health Care Provider policy.
(c) *Ambient Listening Technology.* Health Care Provider and its professionals may use ambient listening technology to record treatment-related communications to help maintain medical record documentation.
(d) *Risks.* There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by Health Care Provider or its professionals will be successful. It is the treating practitioner's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. Health Care Provider's staff may obtain signature for such consent.
(e) *Refusal of Treatment.* Patient has the right to question and refuse treatment; however, should Patient refuse a proposed treatment, Patient agrees and understands that his/her Health Care Providers shall be released from any and all injuries, damages, and liability for failure to provide said treatment to Patient.
(f) *Communicable Disease Testing and Related Release of Information*. Patient voluntarily consents to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if another patient, a health care provider, or other individual furnishing services to Patient at Health Care Provider, a Health Care Provider employee, or an emergency aid worker has a potential exposure from Patient. If such testing becomes necessary, it will be performed at no charge to Patient. In the event an emergency aid worker, such as a paramedic, emergency response employee, or firefighter, first response worker, emergency medical technician, volunteer making an authorized emergency response, or person rendering services as a Good Samaritan in accordance with applicable law is potentially exposed to a life-threatening disease by Patient, Patient consents to Health Care Provider releasing information about Patient to a requesting authority sufficient for such party to determine if Patient has or had such an infection and could have transmitted it to such emergency aid worker.

II. CONSENT TO VIRTUAL SERVICES AND COMMUNICATIONS:

Patient agrees that some services and health care provider consultations may be provided via virtual means, including interactive audio, video, telephone, or other electronic means (hereinafter "Virtual Services") to enable health care providers at different locations to use and disclose Patient medical information for the purpose of providing medical care and treatment. Benefits of Virtual Services include enhanced access to care, patient convenience, reduced risk of exposure to communicable disease, and access to ongoing care and follow-up communication with a health care provider. Medical information is protected to the same extent as a face-to-face visit, although confidentiality and privacy at the off-site location may not be controlled by Health Care Provider. There are risks and limitations to Virtual Services. Virtual Services and care may not be as complete as face-to-face services as a result of a health care provider's potential lack of access to all diagnostic modalities/medical equipment necessary to obtain vital signs, labs, and other pertinent health information to treat Patient, lack of access to complete medical records, and problems with information transmission, including missed information or inaccurate information being transmitted, that could affect a health care provider's medical decision-making. Further, although Health Care Provider uses available encryption and privacy modes for Virtual Services, it is also possible security protocols could fail, causing a breach of privacy of medical information. The alternative is a face-to-face visit, which Patient may request at any time, but an equivalent in-person service may not be available at the same location or time as a Virtual Service. During a Virtual Service, a health care provider may perform a physical exam through the use of technology or a facilitator in the room with Patient. Not all medical conditions can be treated as effectively through a Virtual Service, including emergency conditions. If a health care provider determines a face to-face evaluation is needed, Patient will be referred to an appropriate location for such evaluation. A health care provider can withdraw from a Virtual Service for any reason, including when, in the health care provider's medical judgment, treatment is not safe, private, or effective. In such event, the health care provider can instruct Patient to seek in-person care and Patient agrees to follow such instruction, including for emergency care. Virtual Services are subject to charges, copayments, and deductibles. While a patient may expect the anticipated benefits from the use of Virtual Service, no results can be guaranteed. It is Patient's duty to inform his or her health care provider of electronic interactions that Patient may have with other health care providers. Patient acknowledges that Patient has been informed of the risk and benefits of Virtual Services, understands and agrees to the above, and consents to medical treatment or consultation by means of Virtual Services. Patient also consents to receiving protected health information via email or SMS text messaging and understands that messages through these communication channels may not be secure.

III. CALCULATION AND PAYMENT OF CHARGES: Patient is liable and individually obligated for payment of Health Care Provider's charges on Patient's account and Patient understands and agrees to the following:

(a) Health Care Provider's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. Health Care Provider reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued.

(b) Patient is liable for the uninsured portion of the Health Care Provider bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of Patient.

(c) Health Care Provider has both an uninsured patient discount policy and an indigent care policy. If Patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with Health Care Provider's uninsured patient discount policy. In addition, if Patient is uninsured and meets certain criteria set forth in Health Care Provider's indigent care policy (including, without limitation, income criteria), Patient may be entitled to further discounts to chargemaster rates. Please contact Health Care Provider's financial counselors in our office or Health Care Provider's billing office at 865-331-1982 for more information.

(d) The amount of Health Care Provider charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under Health Care Provider's policies.

(e) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. Patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Health Care Provider's efforts to collect amounts due. Patient hereby authorizes Health Care Provider, and all health care professionals providing care to Patient at Health Care Provider, together with any billing service, collection agency, attorney, or other individual or entity working on their behalf, to contact Patient by cellular and home telephone using prerecorded or artificial voice messages, automatic telephone dialing systems or other computer-assisted technology, text messages, and other forms of electronic communication.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS:
Patient certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, Patient certifies that correct and complete information has been provided regarding Patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to Patient by Health Care Provider, and Patient consents to Health Care Provider's billing such payers for items and services furnished by Health Care Provider to patient. Patient hereby irrevocably assigns to Health Care Provider all rights, title, and interest in compensation or payments otherwise payable to Patient, or received by or on behalf of Patient, for Health Care Provider items or services from any source or payer on file for Patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Patient further assigns to Health Care Provider and any of its parent entities, affiliates, subsidiaries, or assigns any and all rights and benefits Patient has or may become entitled to under any policy of insurance, any type of health plan under the Employee Retirement Income Security Act (ERISA), whether self-funded or otherwise, indemnity agreement, or from any other collateral source or third-party payor of any kind or nature, including all the rights to collect benefits directly from any insurance company, indemnity agreement, health plan covered by ERISA, or from any other collateral source or third-party payor of any kind or nature, and any and all right to proceed against the same in any action, including legal suit, if for any reason any of the same should fail to make payment of benefits due. It is Patient's intent to assign to the fullest extent possible any and all rights Patient has under ERISA to Health Care Provider and any of its parent entities, affiliates, subsidiaries or assigns without limitation. Patient further assigns to Health Care Provider and any of its parent entities, affiliates, subsidiaries or assigns, the right to the proceeds to pay the chargemaster rate for Patient's bill from any claim and/or any action at law or equity for personal injuries which Patient may have, to the extent allowed by law. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to Health Care Provider all amounts due for health care items and services provided to Patient by Health Care Provider. Except as provided in Section III or by law, Patient is financially responsible to Health Care Provider for the charges not covered by these authorizations. Patient understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are Patient's obligation. **Patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined Patient has an HMO or other health plan primary to Medicare and failed to inform Health Care Provider prior to service of such coverage, Patient shall be responsible for paying the account. In the case of series services furnished to Patient by Health Care Provider, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. Patient agrees to sign such further documents as may be reasonably requested to confirm and substantiate Health Care Provider's rights hereunder. Patient further agrees that a copy of this assignment may be used in place of the original copy.

V. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT:
If Patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, Patient must provide such notification and obtain such authorization. Patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, Patient hereby appoints Health Care Provider as Patient's agent for purposes of requesting prior authorization for services Health Care Provider or its practitioners order (e.g., lab services) and agrees Health Care Provider may delegate such appointment. Patient acknowledges there is no guarantee or assurance authorization will be obtained.

VI. ACKNOWLEDGEMENT OF RECEIPT OF NOTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: Patient acknowledges receipt of a Notice of Nondiscrimination, Notice of Language Assistance (as applicable), and Notice of Privacy Practices ("NPP"), all of which are provided at www.covenanthealth.com (Covenant Health - East Tennessee Healthcare and Hospitals) and the terms of which are incorporated into this Agreement by reference. Patient consents to use and disclosure of Patient's protected health information and other patient records (a) consistent with the NPP, including without limitation, for purposes of the treatment, payment, and health care operations functions described in the NPP, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, Patient agrees to disclosure of all or part of Patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at Health Care Provider or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. Patient also consents to release by Patient's health plan or other insurance carrier to Health Care Provider of any eligibility, utilization, or plan data concerning Patient's coverage that may be required.

VII. PERSONAL VALUABLES: Patient agrees that Health Care Provider is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VIII.AMENDMENTS; AUTHORITY OF PATIENT REPRESENTATIVE: Revisions to the Agreement are not effective or enforceable unless accepted in writing by a corporate officer of Health Care Provider. To the extent Patient is not the individual receiving services at Health Care Provider, such individual hereby represents and certifies that he/she is Patient's authorized representative and has all necessary legal authority to enter into this Agreement on Patient's behalf.

IX. ADVANCE CARE PLAN/HEALTH CARE DECISIONMAKER.

Is Patient providing a copy of an advance care plan to include in Patient's medical record today (e.g., living will)?

a. ☐Yes* ☐No

**if yes, provide patient's health care provider with a copy of advance care plan so it can be included in the patient's medical record*

Does the patient want to name a surrogate health care decision-maker?

b. ☐Yes* ☐No

**If yes, name of surrogate health care decision-maker:*_____*and relationship to patient:*_____

X. CONTACTING PATIENT. Patient may be contacted at the following number:_____.

In addition, ***please check one:***

☐ Health Care Provider may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____ Relation to patient:_____ Phone:_____
Name:_____ Relation to patient:_____ Phone: _____

☐ Health Care Provider may not leave messages regarding appointments and lab/test results with anyone other than the patient.

PATIENT HAS READ AND UNDERSTANDS THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREES TO ITS TERMS. A COPY OF THIS AGREEMENT WILL BE PROVIDED ON REQUEST. A COPY OF THIS AGREEMENT WILL BE PROVIDED ON REQUEST.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED_____ Printed Name _____

Patient Name_____ Relationship to Patient _____

Date and Time _____