Covenant Medical Group

Date: _____

Patient Information:

Primary Care Provider:	Provider for Today's Visit:	SSN#:
Name (Last, First, Middle):		Birth Sex: How do you identify, if different than above?
Birth Date:	Age:	Preferred Language:
Veteran (Circle Answer): Yes or No		Ethnicity (Circle Answer): Hispanic or Non-Hispanic
Race (Circle Answer): African American, Alaskan Native, Asian, Hawaiian, Native American Indian, White		Marital Status (Circle Answer): Single, Married, Widowed, Divorced, Legally Separated, Life Partner, Unknown
Mailing Address:		City, State, Zip:
Home Phone:	Cell Phone: Work Phone:	Email Address:
Emergency Contact Name: Relationship to Patient:		Emergency Contact Numbers: Home Phone: Work Phone: Cell Phone:
Referring Physician:		Referring Physician Contact:

If you are a new patient, how did you learn about our office (Circle answer): Direct Mail Family/Friend Internet Ad/Search Newspaper Ad Referral Social Media Other:

If patient is a minor, please fill out this portion:

Parent or Guardian's Name:	Home Phone: Work Phone:	Cell Phone:
Other Parent:	Home Phone: Work Phone:	Cell Phone:

Responsible Party Information (if different from above):

Name (Last, First, Middle):	SSN#:	Birthdate:	Sex:
Address:	City, State, Zip:		
Home Phone:	Cell Phone:	Work Phone:	Relationship to patient:

Primary Insurance (make copies of cards if available, if not, fill in the information below):

Name of Insurance Company:	Name of Insured:	Address of Insured (if different than address above):	
Insured's Birthdate:	Insured's SSN #:	Insured's Insurance ID #:	Relationship to patient:

Secondary Insurance (if applicable):

Name of Insurance Company:	Name of Insured:	Address of Insured (if different than address above):	
Insured's Birthdate:	Insured's SSN#:	Insured's Insurance ID #:	Relationship to patient:

Workers Compensation:

Are you here for workers compensation (Circle): Yes No Date:

Accident (circle answer):

Auto Work Other	Date of Accident:

Registration Staff Signature: _____ Date: _____ Time: _____

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 865-374-5200 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.

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

SIGNED_____ Printed Name _____

Patient Name_____ Relationship to Patient _____

Date and Time _____

Patient Name: _____Date of Birth:_____

APPOINTMENT CANCELLATION AND NO-SHOW POLICY ACKNOWLEDGEMENT

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, we send reminders via phone call or text message 2 days in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least a 24 hour notice.

If you do not cancel or reschedule your appointment with at least a 24 hour notice, we may assess a $35.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of all participating Covenant Medical Group Practices and agree that my account may be charged $35.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no- show charge.

_____ _____

Patient/Guardian Signature Date

Nondiscrimination Notice

This Covenant Health facility, clinic or health care location complies with applicable federal civil rights laws, including without limitation, Title VI of the Civil Rights Act, Section 1557 of the Affordable Care Act, and Section 504 of the Rehabilitation Act, and does not discriminate on the basis of race, color, religion, national origin, age, disability, or sex, or exclude people or treat them differently because of race, color, religion, national origin, age, disability, or sex. Services are provided in a nondiscriminatory manner. All health programs and activities provide:

- Reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats (large print, audio, accessible electronic formats, other formats), free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility, effective communications, and equal opportunity to participate to individuals with disabilities.
- Language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, tell your care provider or the house supervisor/office manager for this location. If you do not speak English or are deaf or are hard of hearing, you can have qualified interpreter services provided at no charge. Tell your care provider or the house supervisor/office manager for this location that you need an interpreter.

If you believe you have been discriminated against on the basis of race, color, religion, national origin, age, disability, or sex, you can file a grievance with our Non-Discrimination Coordinator, Covenant Health Integrity- Compliance Office, 3003 Lake Brook Blvd., Suite 102, Knoxville, TN, 37909, (Telephone) 1-888-731-3115, (Fax) 865-374-8016, (Email) IntegrityCompliance2@covhlth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Non-Discrimination Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
This information is also available at www.CovenantHealth.com