OBSTETRICS GYNECOLOGY

LE CONTE
WOMEN'S HEALTHCARE
ASSOCIATES, P.C.

PATIENT REGISTRATION INFORMATION

*****All Sections Must Be Completed. If not applicable, please indicate as "N/A"*****

_____ _____ _____
Patient's Name – Last, First, Middle | Date of Birth | Social Security Number

_____
Street Address | City & State | Zip Code

If under 18 please provide Responsible Party's information:

_____ _____ _____
Guarantor's Name – Last, First, Middle | Date of Birth | Social Security Number

_____ _____ _____
Guarantor's Driver's License | State Issued | Mailing address (*if different from above*)

Check the boxes to indicate how we may contact you:	**OK to leave a voicemail?**	**OK to leave test results?**
☐ HOME PHONE # _____	yes / no	yes / no
☐ CELL PHONE # _____	yes / no	yes / no
☐ WORK PHONE # _____	yes / no	yes / no

☐ EMAIL ADDRESS _____ *(For our patient portal to see your health & appointment information)*

Which of the above is your preferred method of contact? (*Circle only one*) HOME / CELL / WORK

- **ETHNICITY** (Circle One): Hispanic or Latino / Not Hispanic
- **RACE** (Circle One): Black or African American / White / Hispanic / Asian / American Indian or Alaska Native / Hawaiian or Pacific Islander / Other
- **EMPLOYMENT STATUS** (Circle One): Full-time / Part-time / Self-Employed / Retired / Unemployed
- **EMPLOYER NAME**: _____
- **MARITAL STATUS** (Circle One): Single / Married / Divorced / Widowed / Separated / Other
  Spouse/Partner's Name: _____
  Spouse/Partner's Employer: _____ Spouse/Partner's Work Phone: _____

INSURANCE

DO YOU HAVE INSURANCE? ☐ YES ☐ NO
ARE YOU THE POLICY HOLDER? ☐ YES ☐ NO

INSURANCE POLICY HOLDER'S INFORMATION:

NAME: _____ SEX: M / F BIRTH DATE: _____
PT'S RELATIONSHIP TO INSURED: _____
POLICY HOLDER'S EMPLOYER: _____

May we discuss your healthcare, bills, and arrange appointments with family/friends? YES / NO, do not share w/ anyone.
If yes, please list those individuals that we may talk with:

EMERGENCY CONTACT

Name_____Relationship_____Phone_____ YES / NO

Name_____Relationship_____Phone_____ YES / NO

This authorization will remain in effect until I provide written instructions otherwise.

_____ _____
Signature of Patient or Patient's Representative | Date

740 MIDDLE CREEK RD – SUITE 200 ■ SEVIERVILLE, TN 37862
865.908.9888 ■ FAX 865-908-8756

OBSTETRICS GYNECOLOGY

LE CONTE
WOMEN'S HEALTHCARE
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PATIENT AUTHORIZATION FORM

Patient's Name: _____ **Date of Birth: _____**

(Initial)_____FINANCIAL RESPONSIBILITY:

1. I understand that I am ultimately responsible for payment on my account & payment is expected at the time of service.
2. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles.
3. LWH will file claims for companies we are contracted with, including Medicare, Medicaid and TennCare. Payment of benefits will be made directly to LeConte Women's Healthcare Associates.
4. *I understand and accept that if I make payment with a check and that check is dishonored or returned for any reason, there will be a $**35** processing charge and checks will no longer be accepted.*
5. *Statements are sent out each month on a 30 day billing cycle and are due upon receipt. Please note that you will be asked to pay your balance should you come into the office for an appointment. Accounts that remain unpaid after 90 days may be turned over to an outside collection agency and a fee of **43%** of the total balance due will be added to your account.*
6. **Self-Pay patients**: *If you are applying for insurance or changing benefits, it is critical that you inform us and keep us informed of the progress. You will be considered self-pay, and payment will be expected at the time of service, until we receive confirmation of active coverage.*

(Initial)_____INSURANCE COVERAGE: I understand that I am responsible for providing any and **ALL** insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information. It is considered insurance fraud if you do not disclose all insurance coverage to our office.

(Initial)_____LABORATORY FEES: I understand that my physician uses LabCorp. LWH cannot guarantee my insurance will cover any lab/pathology performed at or ordered by my physician. If my insurance requires use of a different lab, I understand it is my responsibility to inform my physician for proper handling.

(Initial) I DO_____ I DO NOT_____ CONSENT to necessary examinations and/or treatments performed and prescribed by my physician, or nurse practitioner as is necessary in his/her judgment, with patient approval. ***Separate consent forms will be signed for procedures performed in the physician's office.***

(Initial) I DO_____ I DO NOT_____ CONSENT to my medication history being obtained without limitation or exclusion, from my pharmacy, my health insurance and my other healthcare providers. An accurate medication history is important to help us treat you and to avoid potentially dangerous drug interactions.

(Initial)_____RELEASE OF INFORMATION: I do hereby authorize my physician to release information to the hospital facility in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

(Initial)_____HIPAA: The Health Insurance Portability and Accountability Act is a federal law designed to protect patients' medical records and privacy. I acknowledge that I have received or have access to a copy of LWH's Notice of Privacy Practices and I have had the opportunity to ask questions. If you would like a copy of the notice, please ask the front desk. (**Office use only:** *I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because _____**Staff Iinitials**_____)*

_____ _____

Signature of Patient or Patient's Representative Today's date**:**

LeConte Women's Healthcare
740 Middle Creek Road, Suite 200 ~~ Sevierville, TN 37862
Phone: (865) 908-9888 ~~ Fax: (865) 908-8756
Richard L. Love, MD
Jennifer Greene, APRN, BC ~~ Whitney Fulwiler, WHNP

It is our goal to provide the best pre-natal care for you and your baby. In order to do that, we must have the most complete information about your health and the status of your baby. Throughout your pregnancy, we will ask you to provide information and specimens to us that we will use to develop a complete treatment plan for you and your baby. We will ask you to provide urine and other specimens at every visit or as determined necessary by your physician that we will use to perform various tests, including testing for the presence of illicit or non-prescribed controlled substances. The results of these tests will be discussed with you and will only be used by those involved in the care and treatment of your baby, unless otherwise required by law. Without this information, we cannot form a comprehensive clinical plan for the care of you and your baby. Thank you for assisting us with providing the best care for you and your baby.

_____ _____

Patient Signature Date