KNOXVILLE FNA CLINIC
DANIEL SNYDER, DO
139 Fox Road, Suite 203 | Knoxville, TN 37922
Office: 865.888.7747 Fax: 865.888.7748

Patient Demographics

Full Legal Name_____

Date of Birth_____ **Sex- Male Female** **Social Security Number**_____

Billing/Mailing Street Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Cell Phone**_____

Employer/Occupation_____

Marital Status_____

Emergency Contact Name _____ **Phone**_____

Relation to Patient_____

Payment Policy/ HIPAA Notice of Privacy Practices Acknowledgment

Estimated charges for services rendered can range from $450-$1200 depending on extent of procedure and other testing necessary to render a pathologic diagnosis, but could be more or less than this estimate depending on actual testing needed and adjustment by your insurance company. If you have insurance coverage, you must pay the amount the insurance does not cover, such as the deductible and co-insurance. **If you have a copay, we are required to collect it on the day of service. All accounts are to be paid in full within 90 days from date of service.** Payments can be made by cash, check, credit card or debit card. If a check is returned to us for any reason, a $20.00 service charge will be added to your account. As a courtesy, our office will file your insurance. Your insurance policy is a contract between you and your insurance company. You are responsible for payment of all services rendered, whether your insurance company has paid. It is important to understand that your insurance company may not pay all of the charges and the difference between what they pay, and your total charges are your responsibility. **Outstanding balances may be pursued by third-party collections.** Our office can help you with problems which may arise with your claim, but our office does not accept the responsibility for negotiating a settlement on a disputed claim. **All bills will be from University Physicians' Association / Dermatopathology Partners, d.b.a. Knoxville FNA Clinic**.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call or text my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

I have read the above payment policy and understand that I am responsible for payment of my account. I assign and request payment of medical benefits to physician for services. I acknowledge that I have received and read a copy of your HIPAA Notice of Privacy Practices. This notice describes in detail how we might disclose my protected health information to carry out normal healthcare procedures, treatment, or payment. The notice also describes my rights and your duties with respect to my protected health information.

Patient/Guardian Signature_____ **Date** _____

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Date_____

Patient Review of Systems

Full Legal Name_____ **DOB**_____

	Yes	No		Yes	No
General			**Neurological**		
Fatigue			Headaches		
Fever			Dizziness		
Chills			Seizures		
Weight Loss			Tremors		
Night Sweats			**Cardiac/Musculoskeletal**		
Neck/Throat			Chest Pain		
Soreness			Inability to lie flat		
Difficulty Swallowing			**Gastrointestinal**		
Lump(s) on neck			Heartburn or indigestion		
Respiratory			Reflux		
Shortness of Breath			**Hematologic**		
Cough			Bleed easily		
Wheezing			Are you on a blood thinner? (including aspirin)		

Do you have a history of cancer (including skin cancers)? Yes No

If yes, what type and year:_____

Radiation? Yes No

Do you smoke? Yes No How many packs a day?_____ **How long?**_____

Have you ever used tobacco products? Yes No How long? _____**When did you quit?**_____

Do you drink alcohol? Yes No How many drinks a week?_____

Do you have pets? Yes No What kind (dog, cat, etc)? _____

Do you have an allergy to latex? Yes No

Please list any allergies:

_____

_____

_____

Anything else you believe we should be aware of, medically?

_____

_____

_____