KNOXVILLE FNA CLINIC
DANIEL SNYDER, DO
123 Fox Road, Suite 201B | Knoxville, TN 37922
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Patient Demographics

Date:_____

Patient Information

First Name_____ **Last Name**_____ **MI**_____
Date of Birth_____ **Social Security Number**_____
Sex (Circle one) **M** **F**
Street Address_____
City_____ **State**_____ **Zip Code**_____
Home Phone_____ **Cell Phone**_____
Employer_____ **Work Phone**_____
Marital Status_____
Emergency Contact Name _____ **Phone**_____
Relation to Patient_____

Insurance Holder Information or Guarantor Information

Patient Relation (*i.e. self, wife, husband, father mother, guardian*) _____
Guarantor First Name_____ **Last Name**_____ **MI**_____
Date of Birth_____ **Social Security Number**_____
Guarantor Address _____**City**_____
State_____ **Zip Code**_____ **Phone Number** _____
Employer_____ **Work Contact Number** _____
Employer Street Address_____
City_____ **State**_____ **Zip Code**_____

Payment Policy/ HIPAA Notice of Privacy Practices Acknowledgment

Payment or partial payment is required on the day of visit. If you have insurance coverage, we ask that you pay the amount the insurance does not cover, such as the deductible and co-insurance. 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 series 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 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** _____