Date of	
Biopsy:	

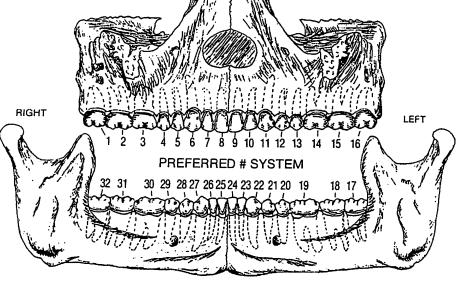
P.O. Box 2484 2400 Susannah Street Suite A

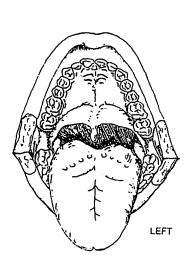
SUSAN D. ROLLINS, MD JANET F. STASTNY, DO YASMIN ELSHENAWY, MD
Lab. No
Date Rec'd in Lab:

PLEASE NOTE: Typing of all information
is now required. Thank you

Phone No. ___

Patient's Name	PLEASE NOTE: Typing of all information is now required. Thank you.	Cyw	center of Johns	son City, TN 3760 Phone: 423.20 Fax: 423.20	83.4734 "1 Lab. —				
Substituted by	Patient's NameLAST		FIRST	MIDDLE	Date of B	irth			
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DURATION OF LESION PROVISIONAL CLINICAL DIAGNOSIS	, C. Li riai	☐ Tende	r 🗆 Asymptomatic	☐ Root inv.	☐ Expansile	į.			
LOCATION OF LESION (check box and circle letters) MAXILLARY MUCOSA Tooth # or area (1-16) L R M Ant. # Post. L R Post. L R	☐ Indurated ☐ Vesicle	DU	PROVISIONAL CLINICAL DIAGNOSIS						
MAXILLARY MUCOSA Palate, Hard L R M Palate, Hard L R M Sofi L R M Comm. L R M Ant. % Post. % L R Comm. L R M Comm. Com	Size of Lesion in mm:								
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Coper L R M Lower Full Partial Lower L R M Hygiene: Good Fair Poor Po	Gingiva 🗋 L, R; B. L		Lip:	Denture:	• •				
*Please have patient sign the payment policy located on the back of form and furnish a copy of insurance card(s). Return pathology report to: Or Additional history and diagrams are located on the back of this form.	Ridge 🗀 L, R; B, L	(1	Hygiana					
located on the back of form and furnish a copy of insurance card(s). Return pathology report to: Additional history and diagrams are located on the back of this form.	·		Lower L L R M	Tryglene.	GOOG D Fail				
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Payment Policy

Provider Notice

Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare standards, Medicare will deny payment for that service.

Patient Agreement

As a courtesy, the Outpatient Cytopathology Center will file your claim to your insurance company. If you do not have insurance, the Outpatient Cytopathology Center can work with you. Your insurance policy is a contract between you and your insurance company. You are responsible for payment of all services rendered, whether or not 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.

I have read the above payment policy and I understand that I am responsible for payment of my account.

Assignment: I assign and request payment of medical/dental benefits to the rendering physician for services.

Signed:	Date
Witnessed	