PAYMENT POLICY: Payment or partial payment is required on the day of visit.

Authorization for Assignment of Insurance Benefits, Information Release, and Financial Responsibility

I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company any and all information concerning heath care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, tests, or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, surgery, test, or service being performed. I understand that if I am seen without an authorization I will be considered a self-pay patient and will be required to pay in full for all services performed. **I agree to pay any and all charges that are not covered or are not paid by my insurance plan(s).**

All accounts are to be paid in full within 90 days from date of service. Payment(s) can be made by cash, check, MasterCard, Visa, Discover, American Express, or CareCredit. If account is not paid, it will be placed with our collection agency and a 30% service fee will be added to the unpaid balance. If a check is returned to us for any reason, a $30.00 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 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 is your responsibility. 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.
I have read the above payment policy and understand that I am responsible for payment of my account. Assignment: I assign and request payment of medical benefits to physician for services.

_____: Patient/Guardian Initials

Acknowledgment of Patient Privacy

If you would like anyone other than yourself to have access to your information, please complete the section below. I understand that authorization for release of information can only be revoked upon written notice.
(Circle the type of information which you authorize us to share).

Name	Relationship	Phone#		
			Medical Information	Billing
			Medical Information	Billing
			Medical Information	Billing

_____: Patient/Guardian Initials

HIPAA Notice of Privacy Practices Acknowledgment

I have had access to or received, read, and understand your Notice of Privacy Practices and the Notice of Nondiscrimination Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____: Patient/Guardian Initials

Patient/Guardian Signature: _____ Date: _____

This form is valid until further notice, until modified or replaced at the patient's request.

Modified 4-22-2019

Authorization to Release Medical Records/Information

Patient's name:_____

Social Security # (Last 4 digits):_____DOB: _____

I request and authorize _____(office use)_____
to release healthcare information of the patient named above to

Outpatient Cytopathology Center

2400 Susannah Street Suite A

Johnson City TN 37601

Phone #: 423-283-4734 FAX #: 423-283-4736

This request and authorization applies to:

_____ 1. Healthcare information relating to treatment, condition, or dates: _____

_____

_____ 2. All healthcare information.

I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Patient/Guardian signature_____Date: _____

Patient Medical History

Patient Allergies/Sensitivities

☐ None
☐ Latex
☐ Numbing agents _____
☐ _____

Patient History -Social

Smoking:

☐ No
☐ Yes: How Long? _____
Pack(s)/day_____
☐ I quit (when): _____

Chew Tobacco:

☐ No
☐ Yes: How Long? _____
How much? _____
☐ I quit (when): _____

Illicit Drug Use:

☐ No
☐ Yes

Pain Medication:

During the past 30 days have you been prescribed a controlled substance or narcotic by a health care provider?

☐ No
☐ Yes

Currently employed?

☐ No
☐ Yes, occupation:_____

Medications:

_____
_____
_____
_____
_____
_____
_____
_____

Family History of Cancer (mother, father, brother, sister, etc.; cancer type):

_____
_____
_____
_____

Important Medical & Cancer History (type, year)

_____
_____
_____
_____

Previous Surgeries or Biopsies (type, year):

_____
_____
_____
_____

Birthplace: _____

Physician Review _____

☐ Susan D. Rollins, M.D.
☐ Yasmin Elshenawy, M.D.