

Dx Code: _____

Case Number: _____

Bill: _____

Fee: _____

Western States Regional Oral & Maxillofacial Pathology Laboratory

12635 E. Montview Blvd., #100

Aurora, CO 80045

Phone: (303) 577-2309

Fax: (720) 859-4110

Medical Director:

Robert O. Greer, Jr., D.D.S., Sc.D.

PATIENT INFORMATION			DOCTOR/CLINIC	
NAME (last, first, MI)			SUBMITTING Dr.	
DATE OF BIRTH / /	AGE	SEX MALE FEMALE	ADDRESS (street)	
ADDRESS (street)		Apartment #	CITY, STATE, ZIP CODE	
CITY, STATE, ZIP CODE			PHONE NUMBER:	
PHONE NUMBER	S.S.#		FAX:	

BILLING/INSURANCE

Please attach a copy of all applicable insurance information

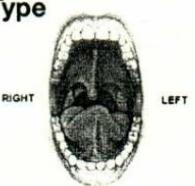
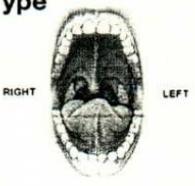
Please Bill: Insurance Patient Medicaid (Medicaid Number: _____) Back to my office

PLEASE NOTE: WESTERN STATES PATHOLOGY DOES NOT PARTICIPATE WITH MEDICARE – IN ORDER FOR ANY MEDICARE SPECIMENS TO BE PROCESSED, A CONSENT FOR MICROSCOPIC TISSUE EVALUATION (PRINTED ON THE REVERSE SIDE OF THIS HISTORY FORM) MUST BE SIGNED AND DATED BY THE PATIENT AND RETURNED WITH THE BIOPSY SPECIMEN.

Name of Insured Person	Relationship to Insured
Company Name	Member ID#

SPECIMEN DATA

Biopsy Date / /

A	Type <input type="checkbox"/> Excision <input type="checkbox"/> Incision <input type="checkbox"/> Other		Clinical description and duration of lesion:
	Location:		Radiographic Appearance:
			Differential Diagnosis:
B	Type <input type="checkbox"/> Incision <input type="checkbox"/> Excision <input type="checkbox"/> Other		Clinical description and duration of lesion:
	Location:		Radiographic Appearance:
			Differential Diagnosis:

PLEASE HAVE ALL PATIENTS/RESPONSIBLE PARTIES – NOT JUST MEDICARE OR MEDICARE-AGED PATIENTS—SIGN THE FORM ON THE REVERSE SIDE OF THIS BIOPSY REQUEST FORM

This must be signed in order for us to process their tissue sample. In accordance with CLIA/CAP Laboratory Accreditation requirements, please make sure the request form AND the specimen bottle label are totally filled out.

Please check with the post office to see what the required postage is to mail your specimens to us. UPS and FedEx are also options for better tracking of your specimens

**WESTERN STATES REGIONAL
ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY
ROBERT O. GREER, JR., D.D.S., Sc.D.**

**12635 E. MONTVIEW BLVD., #100
AURORA CO 80045
303-577-2309/FAX 720-859-4110**

DOCTOR: Please have your patient read, sign, and date this consent form prior to your biopsy. The completed form must be enclosed with the specimen. Please make a photocopy of this signed form for your patient.

CONSENT FOR MICROSCOPIC TISSUE EVALUATION

Your doctor has done a thorough examination of your mouth and has determined that you need to have a biopsy procedure performed. The tissue removed during today's surgery will be sent to WESTERN STATES REGIONAL ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY for microscopic examination and diagnosis. Your doctor is ensuring your good health by making sure that any abnormal tissue removed is examined microscopically so that a definitive diagnosis can be made and the correct treatment rendered. A board certified Oral and Maxillofacial Pathologist will fax a written report of the test results to your doctor. Your doctor will discuss the test results with you.

You will receive a bill directly from WESTERN STATES REGIONAL ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY for this service, which is separate from the fee charged by your surgeon. Based upon the differing complexities of each tissue sample we receive, our fees may vary. In case of multiple tissue sites, each site will have a separate fee. Decalcification of hard tissue such as bone or teeth, evaluation of tissue margins for disease or tumor, and special stains entail additional charges.

As a courtesy to you, we will bill medical insurance companies for our services. We are not members of any preferred provider networks. Therefore, insurance payments are not considered "payment in full." We will request your insurance company to reimburse you directly. Payment in full is due within 30 days from when you receive the bill regardless of your insurance coverage, unless special arrangements have been made in advance with our office. **Health Maintenance Organizations (HMO) plans will not cover our charges.** Claims will only be submitted to HMO plans when we have received prior authorization. **We are not providers of any State Benefits Programs or Medicare providers. They do not cover our services.** All patients are responsible for payment regardless of their insurance plan. Payments from other types of medical plans vary depending upon your coverage. Should collection action be instituted to collect any part of this obligation, the below signatory agrees and promises to pay all collection costs including, but not limited to, court costs and attorney fees. We DO NOT accept payment by Visa or Mastercard.

In order for WESTERN STATES REGIONAL ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY to process your biopsy specimen, you must sign and date the statement below.

WESTERN STATES REGIONAL ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY has my permission to release medical or other information necessary to submit claims to my insurance company on my behalf. If a financially responsible party has been designated, I authorize WESTERN STATES REGIONAL ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY to communicate to them information necessary for billing and insurance purposes. I hereby authorize, if applicable, my insurance company to pay benefits directly to WESTERN STATES REGIONAL ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY. This consent will be valid for one year from the date signed.

I have read and understand the above, and consent to microscopic tissue evaluation of this biopsy specimen. I understand that I am responsible for payment for all services provided by WESTERN STATES REGIONAL ORAL & MAXILLOFACIAL PATHOLOGY LABORATORY.

Signature of Patient, Legal Guardian
Or Holder of Power of Attorney

Print Name

Date