

ORAL PATHOLOGY ORDER FORM



SCRIPPS ORAL PATHOLOGY SERVICE

5190 Governor Drive, Suite 106
San Diego, CA 92122-2848

(858) 784-0600
(858) 784-0604 fax

www.scrippsoralpathology.com

Oral & Maxillofacial Pathologists
Gordon M. Rick, DDS, MS
Lee J. Slater, DDS, MS
Gretchen S. Folk, DDS, MS

LAB USE ONLY

Specimen No. _____
Postdated _____
Received _____

ORDERING DOCTOR

Doctor	Specialty
Address	
City	State ZIP
Phone () ()	Fax () ()
Lic#	NPI E-mail

PATIENT

Last name		First name (not nickname)		Initial	
Social Security No		Birthdate		Age Gender M F	
Mailing address				Apt. No.	
City		State		Zip	
Home phone () ()		Work phone () ()			
Cell Phone () ()		E-mail			

NOTE: Complete current doctor, patient and billing information is required before specimen will be processed.

Name of ordering doctor's billing/insurance contact person _____

SEND BILL TO

1 Patient listed above CALIFORNIA LAW PROHIBITS LABORATORIES FROM BILLING ORDERING DOCTORS FOR PATHOLOGY SERVICES.

2 Financially Responsible Person (If other than patient above) spouse father mother other _____

Last name		First name		Initial		SS#		Birthdate	
Mailing Address						Apt. No.		Home phone () ()	
City				State		Zip		Work phone () ()	

NOTE: Please inform patient of Prepayment Discount option near bottom of *Patient Consent for Oral Pathology Services*

HEALTH INSURANCE INFORMATION – attached copies of front and back of insurance cards required.

NOTE: As a courtesy to patients with health insurance, a claim will be submitted to insurance carrier(s) when current valid information is provided. HMO insurance plans do not cover laboratory charges unless pre-authorized (attach pre-authorization notice here). This lab is not a contracted provider for State-Funded Plans (Medicaid, Med/Dental) and is Opted-Out of Medicare.

MEDICAL

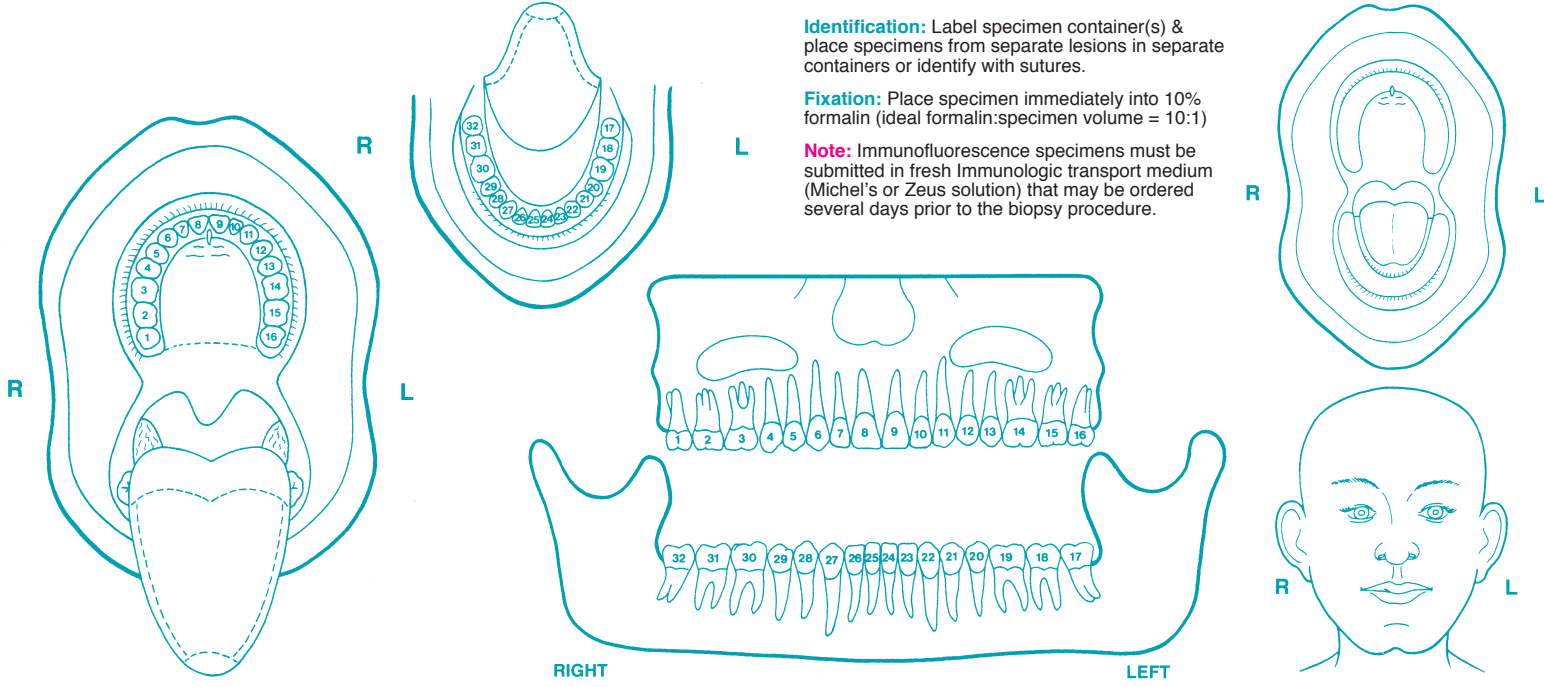
Last name of insured		First name		Birthdate		Gender <input type="checkbox"/> female <input type="checkbox"/> male	
Subscriber ID#		Patient relationship to insured <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other _____			Employer		
Insurance Company						Group #	
Claims Mailing Address				City		State Zip	

Medicare Patients: All medicare patients must sign the attached Medicare Opt-Out Private Contract before their specimen will be processed. Missing signatures will delay specimen processing and diagnosis.

DENTAL

Last name of insured		First name		Social Security No.		Birthdate		Gender <input type="checkbox"/> female <input type="checkbox"/> male	
Subscriber ID#		Patient relationship to insured <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other _____			Employer				
Insurance Company						Group #			
Claims Mailing Address				City		State Zip			

NOTE: THE ATTACHED PATIENT CONSENT FOR ORAL PATHOLOGY SERVICES MUST BE SIGNED BY THE PATIENT OR FINANCIALLY RESPONSIBLE PERSON **AND IT MUST BE ENCLOSED WITH THE SPECIMEN TO AVOID A LAB PROCESSING DELAY.**



Identification: Label specimen container(s) & place specimens from separate lesions in separate containers or identify with sutures.

Fixation: Place specimen immediately into 10% formalin (ideal formalin:specimen volume = 10:1)

Note: Immunofluorescence specimens must be submitted in fresh Immunologic transport medium (Michel's or Zeus solution) that may be ordered several days prior to the biopsy procedure.

IMPORTANT: Failure to provide pertinent information will delay diagnostic report

RELEVANT CLINICAL INFORMATION

SUMMARY OF CURRENT PROBLEM (reason for biopsy/surgery) _____
(symptoms, duration, previous related treatment, etc.)

MEDICAL / DENTAL HISTORY _____
(pertinent diseases, drugs & medications, oral habits, family history, etc.)

CLINICAL FINDINGS _____
(size, shape, color, consistency, etc.)

RADIOGRAPHIC FINDINGS _____
(size, shape, borders, definition, radiolucent vs radiopaque, relation to teeth, etc.)

(radiographic correlation may be required for diagnosis – please submit radiographs with the specimen – originals will be returned with the report)

PRIOR LAB TEST RESULTS _____

CLINICAL IMPRESSION OR DIFFERENTIAL DIAGNOSIS _____

SPECIMEN INFORMATION

ANATOMIC SITE OF SPECIMEN **PROCEDURE**

Specimen "A" _____ Complete excision Incisional biopsy Other _____

Specimen "B" _____ Complete excision Incisional biopsy Other _____

(use an additional form when more than two anatomically separate specimens are submitted)

SURGICAL FINDINGS _____

COMMENTS or SPECIAL INSTRUCTIONS _____

SERVICE REQUESTED

- routine microscopic tissue exam
- second opinion on "outside" slides
- direct immunofluorescence exam (special transport medium required)
- fungal smear examination
- radiographic consultation
- other

REPORT PRIORITY mail fax phone

Post-op date _____ Time _____

SEND COPY OF REPORT TO **(provide fax # or complete address)**

Dr. _____

DATE SPECIMEN OBTAINED

(required) _____

PATHOLOGY SERVICE REQUESTED BY

(Doctor signature required) Dr. _____

SUPPLIES REQUESTED surgical specimen kits (no. _____) other _____

Please visit our website (www.scrippsoralpathology.com) for information about the lab, our board-certified oral & maxillofacial pathologist, descriptions of lab services, how to obtain maximally diagnostic specimens, and to download ORAL PATHOLOGY ORDER FORMS.

LAB USE ONLY Charge code

Images received

Diagnosis code



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Billing Office (858) 784-0605
Fax (858) 784-0604

DOCTOR: Please have your patient read, sign and date this consent form prior to your biopsy or other diagnostic procedure—it must be enclosed with the specimen. Please give the patient a photocopy of this signed consent.

PATIENT CONSENT FOR ORAL PATHOLOGY SERVICES

As a result of thorough evaluation by your doctor, a specimen is being sent to Scripps Oral Pathology Service for analysis and diagnosis. Your doctor is demonstrating his/her concern for your health by having the removed tissue analyzed by our board-certified Oral and Maxillofacial Pathologists to establish a precise diagnosis and assure correct treatment.

You will receive a bill directly from Scripps Oral Pathology Service and you are responsible for your laboratory charges since they are not included in your doctor's charges. The usual fee for our most common routine pathology service is \$310 per specimen.

Any insurance policies you have are contracts between you and your insurance company and do not obligate them to pay us or to reimburse you for our services. However, as a courtesy to you, we will submit a claim to your primary medical and/or dental insurance carriers when we receive a copy of both sides of your current valid health insurance cards or complete insurance information on the attached form that is sent to us with your specimen.

Our Privacy Commitment to You. The protected health information your doctor provided to us will be used only for diagnostic, billing, scientific research, professional education or other business operations within HIPAA regulations.

IN ORDER FOR SCRIPPS ORAL PATHOLOGY SERVICE TO PROCESS YOUR SPECIMEN, THIS CONSENT AND FINANCIAL AGREEMENT MUST BE SIGNED AND DATED BELOW.

I certify that I have read and understand the information above and that I have received a photocopy of this page. I consent to the laboratory tests needed to analyze my specimen(s) and I have been informed that my doctor is sending it(them) to Scripps Oral Pathology Service for diagnosis.

I understand that I am responsible for the co-payment or deductible requirements of my insurance plan and for payment for any services that are not covered or are ineligible for payment by my insurance policy. If it is determined that I am not eligible for insurance coverage, I agree to pay the fees charged by Scripps Oral Pathology Service.

I understand that I may be personally responsible for payment of pathology services that are needed to diagnose my specimen(s) and I agree to pay for all related charges within 30 days of receipt of a bill. I also agree that if my account is transferred to any outside entity for collection, I will pay for the collection agency fee of up to 30% of total charges, reasonable attorney fees and court costs in connection with obtaining payment.

I authorize release of my health and/or financial information to health insurance or similar companies as necessary to process insurance claims for my pathology laboratory charges and I hereby assign my insurance benefits to Scripps Oral Pathology Service. I also authorize release of my information to any collection agency to which my account may be assigned for collection.

Signature of Patient or Responsible Person (legal guardian or holder of power of attorney) Print Name Date

(Please ask for a photocopy of this page if you have not received one)

PREPAYMENT DISCOUNT: A 5% discount will be deducted from your lab bill if we receive complete credit card information below together with your specimen(s). A statement showing the discount and your credit card payment will be mailed to you.

Card No. Expiration date Security No. on back of card

Printed Name as it appears on Card Cardholder Signature

Billing Address City State Zip

Please note: The information provided above was correct when this form was revised in January 2014. However, this information is subject to change due to ongoing insurance company contract and governmental regulatory changes.



Medicare Opt-Out Private Contract

This contract between Drs. Gretchen Folk, Gordon Rick and/or Lee Slater ("Pathologists") and _____ (Medicare beneficiary or legal representative, referred to in this contract as "Patient") allows Pathologists to provide services to Patient without being subject to Medicare limits. To do so, the law requires Pathologists to "opt out" of Medicare and that no Medicare claim will be filed for the treatment of Patient by Pathologists.

Pathologists represent that Pathologists are not excluded from participation under the Medicare program under §1128, 1156 or 1892 of the Social Security Act; in addition, Patient and Pathologists agree that Patient is not now facing an emergency or urgent health care situation.

By signing this contract, Patient or legal representative does the following:

(initial) (i) agrees **not** to submit a Medicare claim (or to request that Pathologists submit a claim) for services or items supplied by Pathologists, even if they are otherwise covered under Medicare;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of services or items supplied by Pathologists, and understands that **no reimbursement will be provided under Medicare** for those services or items; in particular, Patient will pay for such services at Pathologist's usual rate, in accordance with Pathologist's payment policies;

(iii) acknowledges that **Medicare limits do not apply** to amounts that Pathologists may charge for such services or items;

(iv) acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services covered by this contract, because payment is not made under Medicare; and

(v) acknowledges that Patient has the right to have such services or items provided by other pathologists or practitioners for whom payment would be made under Medicare. (Patient is not required to enter into private contracts that apply to other Medicare covered services furnished by other pathologists who have not opted out.)

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Pathologist's current opt-out period. The expected expiration date of Pathologist's opt-out period is March 30, 2016.

I will be furnished a photocopy of this contract. Should CMS request a copy of this contract, I authorize a copy to be sent to them.

Accepted and Agreed: _____
Patient or Patient's Legal Representative Date

Accepted and Agreed: _____
Pathologist Date