ORAL PATHOLOGY ORDER FORM

SCRIPPS ORAL PATHOLOGY SERVICE
6727 Flanders Drive, Ste #104
San Diego, CA 92122

(858) 784-0600
(858) 784-0604 fax
www.scrippsoralpathology.com

Oral & Maxillofacial Pathologists
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#I | 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

SEND BILL TO

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

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

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

☐ **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/Dentical) and is Opted-Out of Medicare.

MEDICAL

Last name of insured | First name | Birthdate | Gender ☐ female ☐ male

Subscriber ID# | Patient relationship to insured ☐ self ☐ spouse ☐ child ☐ 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

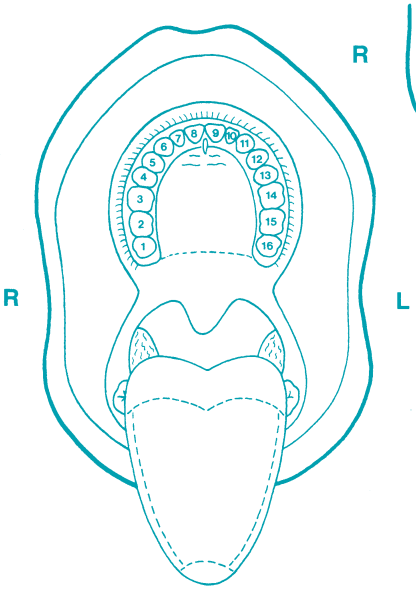
Last name of insured | First name | Social Security No. | Birthdate | Gender ☐ female ☐ male

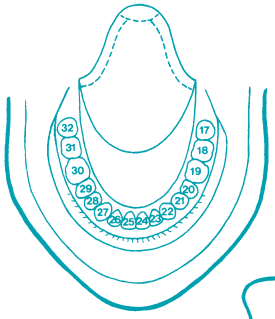
Subscriber ID# | Patient relationship to insured ☐ self ☐ spouse ☐ child ☐ other_____ | Employer

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.

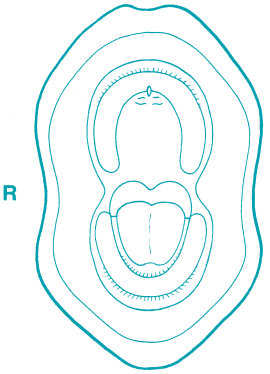


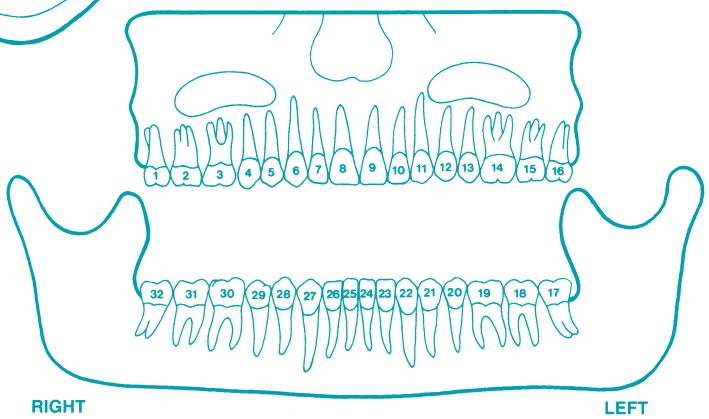


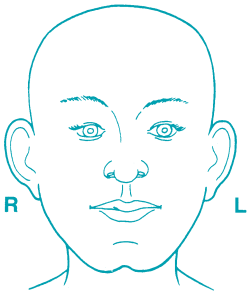
Identification: Label specimen container(s) & place specimens from separate lesions in separate containers or identify with sutures.

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.







RELEVANT CLINICAL INFORMATION

IMPORTANT: Failure to provide pertinent information will delay diagnostic report

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) 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	Images received	Diagnosis code	Charge code

Do Not Detach

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

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. Diagnostic reports are usually completed on the day following receipt of your specimen in the laboratory (unless additional special tests are needed to diagnose it) and your report will be sent to your doctor who will discuss the results with you. If your diagnosis is serious we will telephone your doctor immediately to facilitate any necessary urgent care.

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. However, fees for unusual tests and rarely encountered complex cases are greater and additional charges apply for extra procedures such as special stains to identify microorganisms, decalcification of hard tissue (bone and teeth), etc. Payment is due when you receive our statement and you should pay it promptly to avoid monthly interest and/or late charges. For your convenience, we accept American Express, Discover, MasterCard, VISA credit and debit card payments by telephone, fax or mail.

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. Since we are not contracted with any health insurance companies, determination of benefits with some insurance carriers (including yours) may be affected. Unfortunately our services are not a covered benefit of Kaiser, MetLife, United Concordia and some other plans. Claims will not be submitted to Health Maintenance Organization (HMO) plans (including, Kaiser, Medicare, MediCal and DentiCal) unless pre-authorization for our services has been obtained and the pre-authorization notice is attached to this order form. This Lab is not a provider for State-Funded Plans (Medicaid, MediCal/DentiCal) and has Opted-Out of Medicare.

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. If desired, you may obtain a copy of our complete privacy policy by submitting a request to our compliance officer at the address listed above.

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 agree to be financially responsible and I promise to pay for all of the fees charged for pathology services that are not covered by my health insurance.

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 also acknowledge that if my specimen is sent to Scripps Oral Pathology Service without the proper authorization that may be required by my insurance company, I will pay for the fees charged by Scripps Oral Pathology Service. I also understand that if a service is provided that is not included as a benefit under my insurance coverage, I will be responsible for paying the fee 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. All of my questions regarding my responsibility for payment of pathology services have been answered to my satisfaction. I understand and agree to proceed with the test(s) ordered and related diagnostically indicated services.

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. I also give my permission to Scripps Oral Pathology Service to share my protected health information with other licensed healthcare providers as needed and requested for diagnostic and/or treatment purposes within HIPAA regulations.

_____	_____	_____
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. If this form is being used more than a year after the revision date, you may request of copy of the current version at the address or telephone number listed above or download from our website at www.scrippsoralpathology.com.

Do Not Detach

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

Billing: 858-784-0605
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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

Original Contract Must Be Retained by Pathologist.