Biopsy Examination Request

Requesting Doctor:

Name_____

Address_____
City/State/Zip_____
Phone_____
Fax_____

SOPS Su Oral Pathology Lab Services

31332 Via Colinas, Suite 109
Westlake Village, CA 91362
Tel: 818 865 1039
Fax: 818 865 8375

Lan Su, DMD, PhD. Diplomate American Board of Oral & Maxillofacial Pathology, Director of the Laboratory

www.oralpathmed.com

IMPORTANT- Please complete the information requested below and have the patient sign the informed consent (on a separate paper) prior to processing a biopsy. It will assist us in filing an insurance claim on behalf of your patient.

Patient's Information First_____ Middle _____Last _____ Phone #_____		
Address_____ City_____ State Zip		D.O.B._____Male Female Social Security_____
Name of Responsible Party if not Patient (minor)	Social Security	Phone #-(___)_____ D.O.B Male Female
Address_____City_____State_____Zip_____		
Please send copy of front & back of patient's medical and delta dental insurance cards		
Dental Insurance- Delta_____	Certificate #	Group #-_____
Medical Insurance- Medicare#_____ Other(specify)_____	Certificate #-_____	Group #-_____
Address of Insurance Co. _____	**City of Insurance Co.** _____	**State and Zip Code of Insurance** _____

Lesion Location (Use diagram on reverse) _____ Excision Incision _____

History: _____

_____

_____

_____

Clinical Appearance: _____

_____

_____

Radiographic Appearance (Submission of Radiographs desired):_____

_____

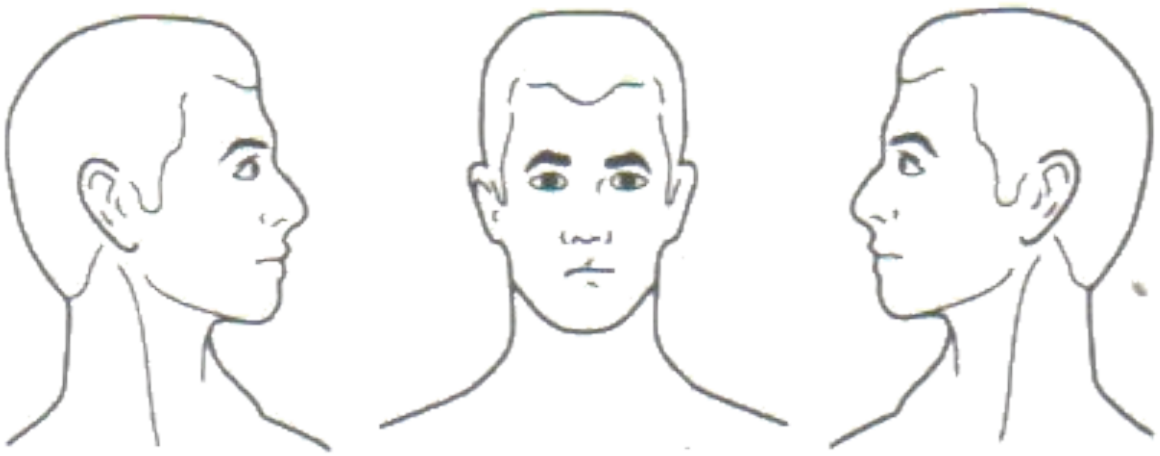
_____

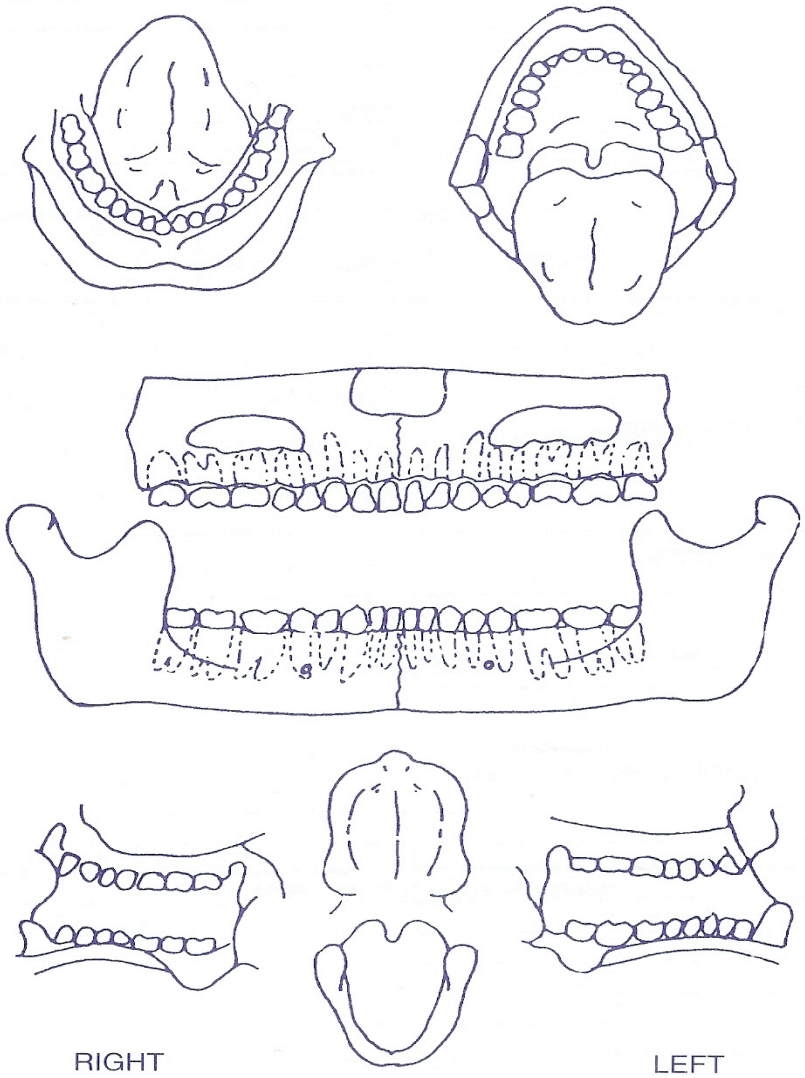
Clinical Impression: _____ **Biopsy Date**: _____

Additional Comments and Information: _____

_____

Lab use only Date Received: X-ray received: yes No Lab. No.





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Dear Doctor: We must have verification of the patient's information consent PRIOR to processing a biopsy. Please have your patient sign and date this form prior to the surgical procedure and return it with the biopsy specimen.

Consent for Microscopic Tissue Evaluation

The tissue removed during today's surgery will be sent to Dr. Su Oral Pathology Services 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. Our board- certified Oral and Maxiofacial Pathologist will fax and send a written report of the results to your doctor, which he/she will discuss with you.

You will receive a bill directly from Dr. Su, Oral Pathology for this service. This is separate from the fee charged by your surgeon. In the case of multiple sites, each site will have a separate fee. Decalcification of hard tissue such as bone, evaluation of margins, and special stains entail additional charges. Payment is due when you receive the bill unless special arrangements for payment have been made in advance.

As a courtesy to you, we will bill applicable insurance companies (excluding Medicare, MediCal, HMOs) for our services, but you are responsible for this account and it should be paid promptly* (see details below). We opt out Medicare. Delta Dental of California may pay a small portion of our charges, but other dental plans may deny coverage. Most insurance plans will generally pay you directly, as we are not "members" of their preferred provider networks and we are also excluded by Medicare.

In order for us to process your biopsy, you must sign and date the statement below.

I have read and understand the above. I consent to the microscopic evaluation of my biopsy specimen, and understand that I will be responsible for payment for all services provided by Dr. Su, Oral Pathology Service and the financial policy stated below*. Dr. Su has my permission to release medical or other information necessary to my insurance company. I also authorize my insurance company to pay benefits directly to Dr. Su, Oral Pathology Service.

_____

Signature of patient or responsible party Print name Date and time

* In order to operate our business more efficiently, you may incur a late fee for a 30-day outstanding balance (a monthly finance charge of 0.5% or a minimum $5.00 administration fee for each additional statement). An outstanding balance over 60 days will be forwarded to our collection agency for further actions with additional fee no more than $100. All legal costs incurred for collection of past due amount will be charged to the patient or responsible party, although this is never our wish to do so.

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