SPECIMEN CONTAINER MUST BE LABELLED WITH PATIENT'S NAME AND BIOPSY SITE

Northwest Oral Pathology

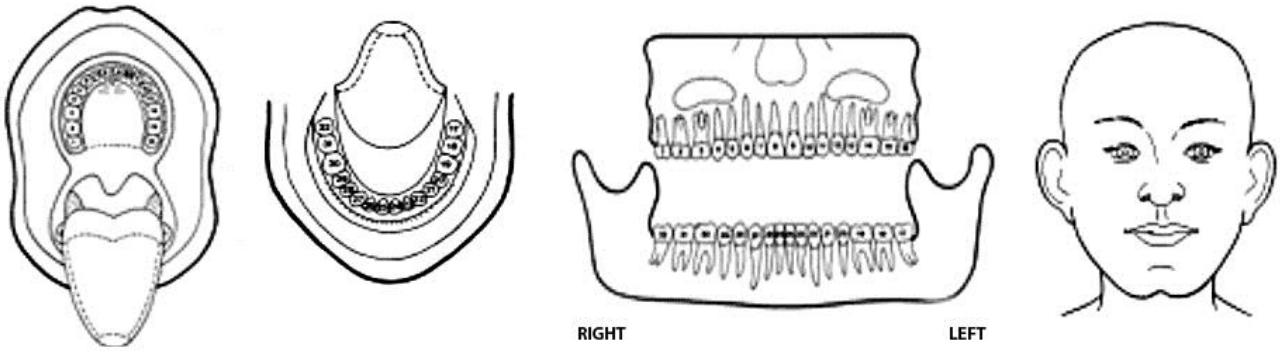
In Affiliation with CTALab

For specimen pick up: 503.906.7300
Images to photos@NWOralPathology.com
12254 SW Garden Place / Tigard, OR 97223
www.NWOralPathology.com

Required

Submitting Clinician (Name and Telephone)	**Today's Date**	**Date of Collection**
Patient Name (Last, First M)	**Patient Date of Birth**	**Sex** M F
Patient Mailing Address (Street or PO Box, City, State, ZIP Code)		**Patient Telephone**

Indicate Location and Extent of Lesion



Specimen Data

Specimen Type

☐ Excisional Biopsy ☐ Incisional Biopsy
☐ Cytology ☐ Immunofluorescence

Images

☐ Images emailed to photos@NWOralPathology.com
☐ Enclosed

☐ X-rays - _____ # enclosed

☐ Photos - _____ # enclosed

Specimen Site

Findings and Gross Descriptions - Submit additional forms for additional specimens

Clinical Description of Lesion (Location, size, color, shape)

History – Lesion / Medical / Dental

Provisional Clinical Diagnosis

Submitting Clinician Signature

Laboratory, Pathologist, & Claim Processing Use Only

Gross (Lab use only)
Specimen Color: ☐ *Tan* ☐ *Gray* ☐ *Brown* ☐ *Other:* _____ ☐ *Inked* ☐ *Sectioned*
Submitted: ☐ *Entirely* ☐ *Partially* _____ x _____ x _____ *mm*

Laboratory	
Count	CPT Code
	88304
	88305

Laboratory	
Count	CPT Code
	88307
	88311

Laboratory	
Count	CPT Code
	88312
	88313

Laboratory	
	88342
	88346

Laboratory	

(Complete Form on reverse)

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Bill to: ☐ Insurance ☐ Patient ☐ Clinician (Attach or fill in information)	
Medical Insurance	
Primary Medical Insurance	**Secondary Medical Insurance**
Policy Holder's Name	Policy Holder's Name
ID/Group Numbers	ID/Group Numbers
Billing Address	Billing Address

All patients must sign below before biopsy submission.

I acknowledge my responsibility for all charges for the laboratory services requested on my behalf by of my dentist/physician and authorize the release of information, including medical information, for this and any related claim, to the named insurance companies. **Northwest Oral Pathology is not 'in network' for any insurance program**. I also acknowledge responsibility for any of these laboratory charges that are not covered or are partially covered/authorized by my health and/or dental insurance provider.

Patient Signature **Date**

Medicare Patients must read and sign below before biopsy submission.

This contract between Dr. F. James Kratochvil and/or Dr. Cynthia L. Kleinegger (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 services to the 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:

- Agrees **not** to submit a Medicare claim (or to request that the Pathologists submit a claim) for services or items supplied by Pathologists, even if they are otherwise covered by Medicare;
- 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 the Pathologist's usual rate, in accordance with Pathologist's payment policies;
- Acknowledges that **Medicare limits do not apply** to the amounts that Pathologists may charge for such services or items;
- Acknowledges that Medi-Gap 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
- 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 Pathologist's opt-out period. The expected expiration date of Pathologist's initial opt-out period is/was 12/31/2017. The opt-out will be renewed every two years thereafter for additional opt-out periods. 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.

Pathologist Signature

Medicare Patient Signature **Date**

PRINT