Dynamic Pathology
Oral and Maxillofacial Pathology

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REQUEST FOR ORAL PATHOLOGY TISSUE EXAMINATION

Patient Last Name: _____First Name: _____

Date of Birth: Mo_____ Day_____ Yr_____ Sex_____ Phone: ( ) _____

Address: _____

City: _____State: _____ Zip: _____

Billing Information (Please submit copy of insurance card and picture ID). Check option below:

☐ Bill Medical Insurance ☐ Bill Dental Insurance

Insurance – Name of Policy Holder: _____SS#:_____

☐ Self-pay – Name of Responsible Party: _____

Billing Address (if different than patient):_____

I consent to have my tissue biopsy sent to Dynamic Pathology and have read and signed the financial agreement (on the back of this form) and Medicare opt-out contract (if applicable).

Patient Signature: _____

Date of Biopsy: _____ Specimen Site: _____

Type of Biopsy: ☐ Incisional biopsy ☐ Excisional Biopsy ☐ Teeth/Bone ☐ Specimen for DIF

Radiographs/photos: ☐ Included ☐ Emailed (biopsy@dynamicpathology.com)

Clinical History: (onset, course, appearance/size of entire lesion, etc.) _____

_____

_____

_____

Differential Diagnosis: _____

_____

Additional information/instructions to pathologist: _____

_____

SUBMITTING DOCTOR NAME: _____

Office Location (if more than one office):_____

Office address: ☐ **On File all below**

_____

City/State/Zip:_____

Office Phone: _____ Doctor's NPI #: _____ Fax:_____

Email Path report to: _____

Supplies: Need # of complete biopsy kits: _____ Formalin bottles: _____ DIF (Michel's) solution: _____

Other: _____

FOR ALL ACCOUNT & BILLING QUESTIONS
Dynamic Pathology • Oral and Maxillofacial Pathology
Tel: 813-569-0192 or 941-720-9747
Fax: 866-710-4133 • Email: biopsy@dynamicpathology.com

FOR THE PATIENT: IMPORTANT INFORMATION ABOUT ORAL PATHOLOGY LABORATORY BILLING

Your doctor has chosen to send your biopsy specimen to Dynamic Pathology for expert microscopic examination, diagnosis and reporting by a board certified oral pathologist. **The fee for our laboratory service is not included in your doctor's charge for the biopsy and there will be a separate statement from our billing agency for this service.** Please carefully read the information below.

BILLING POLICY: WHY YOU WILL RECEIVE A STATEMENT FROM DYNAMIC PATHOLOGY

- Effective April 1, 2023, we are **OUT-OF-NETWORK with all insurance companies**.
- As a courtesy, we will bill your dental or medical insurance for this lab procedure on your behalf. If you have out-of-network benefits or have met your deductible, our lab services MAY be covered by your insurance. Please check with your insurance provider if you are uncertain of coverage provisions.
- If you have Medicare or Medicare Advantage insurance, please review, initial, and sign our Medicare opt-out contract. We will NOT file claims with Medicare and you will be responsible for payment in full. If you have a separate dental insurance plan, we will file a courtesy claim with your dental insurance provider.
- **The estimated cost of a routine biopsy is usually $200-300.** If additional tissue processing or tests are required for diagnosis, there are additional fees, but this is only necessary in a small percentage of cases.
- For timely billing, please provide your current contact information (and copy of driver's license or ID card) and insurance information (and copy of insurance card), if applicable. If no insurance information is provided, we will not file a claim and we will send the billing statement directly to you.
- Any disputes with your insurance company involving participating providers, coverage, eligibility or unpaid balances are your responsibility to resolve. Co-insurance, co-payment or deductibles are determined by your insurance plan and are your responsibility.
- All charges are payable once you receive a statement for our services. Please contact us with questions.
- Unless prior arrangements have been made, any balance that has not been paid within 60 days from the date of the statement will be transferred to our professional collection agency, and you may be charged an additional 25% of your outstanding balance, as well as any related legal costs or fees.

Consent for Treatment: I consent to having my biopsy specimen sent to Dynamic Pathology (an out-of-network lab) and the laboratory tests required to process and diagnose my specimen.

Assignment of Benefits: I hereby assign medical benefits to which I am entitled to Dynamic Pathology. I hereby authorize my insurance carrier and any other health/medical plan to issue payment checks to this lab for all pathology services I receive.

Financial Responsibility: I understand that I will be fully responsible to pay for the medical services that I receive from Dynamic Pathology if: (1) my insurance does not cover out-of-network services; (2) I have not met my annual deductible; (3) I have Medicare or a Medicare Advantage plan; (4) I do not have insurance.

I understand that if I have insurance, Dynamic Pathology will file laboratory services to my insurance carrier(s) on my behalf. I attest that the insurance information that I provide is correct and accurate.

Authorization to Release Information: I hereby authorize Dynamic Pathology to: (1) release information necessary to insurance carriers regarding medical services that I receive; (2) share protected health information with other licensed healthcare providers as needed for diagnostic and treatment purposes within HIPAA regulations.

_____ _____

Patient signature **Date**