TEXAS A&M UNIVERSITY
College of Dentistry

ORAL PATHOLOGY SERVICES
3302 Gaston Avenue #212
Dallas, TX 75246
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DATE	☐ EMAIL RESULTS ☐ FAX RESULTS	PATH NUMBER
PATIENT NAME (LAST, FIRST)		BILL TO *(Please check one)* ☐ Doctor ☐ Patient ☐ Medical Ins. ☐ Dental Ins. ☐ Medicare/Medicaid ☐ Monarch ***If not marked, doctor's office will be billed***
ADDRESS		
CITY	STATE / ZIP	
AGE / SEX / RACE / PATIENT'S DATE OF BIRTH		

PROVISIONAL DIAGNOSIS	**BILLING INFORMATION *(Please type or print clearly)*** **PATIENT ADDRESS, DOB, AND HOME PHONE REQUIRED**	
CASE HISTORY AND DESCRIPTION	INSURED'S NAME	PATIENT'S HOME TELEPHONE
	PATIENT'S SS#	INSURED'S DATE OF BIRTH
	INSURANCE COMPANY	INSURED'S SS#
	INSURANCE ADDRESS	INSURANCE TELEPHONE
	INSURANCE GROUP #	INSURANCE POLICY #
BIOPSY LOCATION: _____ ☐ INCISIONAL ☐ EXCISIONAL RADIOGRAPHS: ☐ YES ☐ NO ☐ ENCLOSED	MEDICARE #	MEDICAID #
DOCTOR'S NAME	LAB USE ONLY *(Do not write in this space)*	
ADDRESS	☐ 88161 ☐ 88307 ☐ 88313 ☐ 88341 ☐ 88302 ☐ 88309 ☐ 88321 ☐ 88____ ☐ 88304 ☐ 88311 ☐ 88323 ☐ 88____ ☐ 88305 ☐ 88312 ☐ 88342 ☐ 88____	
CITY / STATE / ZIP		
PHONE / FAX		
EMAIL	ICD10 Dx Code: _____	

Dear Doctor: We must have verification of the patient's 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. If the patient has medical insurance, please also include a copy of both sides of his/her current valid health insurance card or complete insurance information on the attached form.

PATIENT CONSENT FOR MICROSCOPIC EVALUATION OF TISSUE

The tissue removed during today's surgery will be sent to Texas A&M 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 by the most medically qualified specialists so that a definitive diagnosis can be made and the correct treatment rendered. Our board- certified Oral and Maxillofacial Pathologist will fax/email and send a written report of the results to your doctor, which he/she will discuss with you. You will receive a separate bill directly from Oral Pathology Services for this service. This is separate from the fee charged by your doctor. In the case of multiple sites, each site will have a separate fee. Decalcification of hard tissue such as bone, evaluation of margins, special stains, and other studies may entail additional charges. Payment is due when you receive the bill unless special arrangements for payment have been made in advance. Failure to pay the full amount due within 30 days of the date of service may result in the referral of your outstanding balance to an outside collection agency and/or may be reported to a credit reporting agency. Any insurance policies you may have are contracts between you and the insurance company and do not obligate them to pay us or reimburse you for our services. As a courtesy to you, we will submit a claim to your primary medical insurance carrier 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 every health plan, determination of benefits with some insurance carriers may be affected. Some carriers may pay in full, some only a small portion of our charges, but other plans may deny coverage. **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 Texas A&M Oral Pathology Services. Texas A&M Oral Pathology Services 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 Texas A&M Oral Pathology Services. This consent will be valid for one year from the date signed.

_____ Patient name (print)

_____ Patient signature

_____ Date