oral pathology consultants
at The Ohio State University

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Patient Consent for Oral Pathology Services

DOCTOR: Please have your patient, read, sign and date this consent form prior to your biopsy. The completed form must be enclosed with the specimen. **Please make a photocopy of this signed form for your patient.**

PATIENT: Your doctor has determined that you need to have a biopsy procedure performed. The tissue removed during today's surgery will be sent to Oral Pathology Consultants at The Ohio State University for microscopic examination and diagnosis. Our board-certified Oral and Maxillofacial Pathologists will send a written report of the test results to your doctors. Your doctor will discuss the test 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 Oral Pathology Consultants Laboratory, Inc for our diagnostic services since they are not included in your referring doctor's charges. You are responsible for your laboratory charges. Payment is due when you receive our statement and should be paid promptly. For your convenience, we accept American Express, Discover, MasterCard, VISA, HSA/FSA credit and debit card payments.

Any insurance policies you may have are contracts between you, the employer (if applicable) and the insurance company and do not obligate them to pay us or reimburse you for our services. However, as a courtesy to you, we will submit a claim to your primary and secondary medical 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 every health plan, determination of benefits with some insurance carriers (including yours) may be affected. Please provide us with *medical* insurance information only, as our services are not covered by dental insurances.

Our Privacy Commitment to You. The protected health information your doctor provided to us will be used only for diagnostic, billing, 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 ORAL PATHOLOGY CONSULTANTS LABORATORY TO PROCESS YOUR SPECIMEN, THIS CONSENT AND FINANCIAL AGREEMENT MUST BE SIGNED AND DATED BELOW.

I certify that I have read and understand the above and I have received a photocopy of this consent, financial agreement and authorization.

I consent to the laboratory tests needed to diagnose my specimen(s). I understand that I am financially responsible and I promise to pay for all of the diagnostic services provided by Oral Pathology Consultants Laboratory that are not paid in full or covered by health insurers (including deductibles). Should my account become past due I understand it will be referred to a collection agency who reports to credit agencies.

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 the Oral Pathology Consultants Laboratory.

I authorize release of my information to any collection agency to which my account may be assigned for collection.

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

Patient's Name: _____
(Print Patient's Name)

_____ _____ _____
Signature of Patient or Responsible Person: Print Name: Date:
(Legal Guardian or Holder of Power of Attorney)