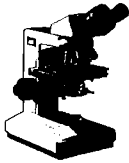



**ORAL PATHOLOGY ASSOCIATES, INC.**

*Tissue Diagnosis & Consultation for the Health Care Professions*

**AUDREY L. BOROS, M.Sc., D.D.S.**
**RAYMOND J. MELROSE, D.D.S.**
*Diplomates, American Board of Oral and Maxillofacial Pathology*


| *For Laboratory Use Only* | Doctor No. - |
|---|---|
| Date Received - | OPA No. - |


11500 W. Olympic Blvd., Suite 390, P.O. Box 64720, Los Angeles, CA 90064-0720
Telephone: (310) 235-1164 • Fax: (310) 235-1067 • Website: www.oralpathologyassociates.com


# BIOPSY EXAMINATION REQUEST

**REQUESTING DOCTOR**

| DOCTOR | | |
|---|---|---|
| ADDRESS | | SUITE NO. |
| CITY | STATE | ZIP |
| PHONE ( ) | FAX ( ) | |
| LICENSE # | NPI # | |
| E-MAIL | | |

**PATIENT**

| LAST NAME | FIRST NAME | | INITIAL |
|---|---|---|---|
| SOCIAL SECURITY NO. | BIRTHDATE | | GENDER M F |
| MAILING ADDRESS | | | APT. NO. |
| CITY | | STATE | ZIP |
| HOME PHONE ( ) | WORK PHONE ( ) | | |
| CELL ( ) | | | |

**SEND BILL TO**

☐ **Patient** ***California state law prohibits this laboratory from billing Doctors offices for our services***

☐ **Financially Responsible Party:** ☐ spouse ☐ parent ☐ other ____________

| LAST NAME | FIRST NAME | SOCIAL SECURITY NO. | | BIRTHDATE | HOME PHONE ( ) |
|---|---|---|---|---|---|
| MAILING ADDRESS | | | | APT. NO. | WORK PHONE ( ) |
| CITY | | STATE | ZIP CODE | EMPLOYER | |

## HEALTH INSURANCE INFORMATION – attached copies of front and back of insurance cards required.

**NOTE:** As a courtesy to patients with health insurance, a claim will be submitted to insurance carrier(s) when current valid information is provided. HMO insurance plans do not cover laboratory charges unless pre-authorized (attach pre-authorization notice here). This lab is not a contracted provider for State-Funded Plans (Medicaid, Med/Dentical) and is Opted-Out of Medicare.

**MEDICAL**

| LAST NAME OF SUBSCRIBER | FIRST NAME | BIRTHDATE |
|---|---|---|
| SUBSCRIBER ID# | PATIENT RELATIONSHIP TO INSURED ☐ self ☐ spouse ☐ child ☐ other ____________ | EMPLOYER |
| INSURANCE COMPANY | | GROUP # |
| CLAIMS MAILING ADDRESS | | |

**Medicare Patients: All medicare patients must sign the attached Medicare Opt-Out Private Contract before their specimen will be processed. Missing signatures will delay specimen processing and diagnosis.**

**DENTAL**

| LAST NAME OF SUBSCRIBER | FIRST NAME | SOCIAL SECURITY NUMBER | BIRTHDATE |
|---|---|---|---|
| SUBSCRIBER ID# | PATIENT RELATIONSHIP TO INSURED ☐ self ☐ spouse ☐ child ☐ other ____________ | | EMPLOYER |
| INSURANCE COMPANY | | | GROUP # |
| CLAIMS MAILING ADDRESS | | | |

**SUPPLIES REQUESTED** ☐ Please send our office _______ complementary biopsy kits.

Please visit our website (www.oralpathologyassociates.com) for information about the lab and our American Board of Oral and Maxillofacial Pathology-certified pathologists, descriptions of laboratory services, methods to obtain maximally diagnostic specimens, downloadable ORAL PATHOLOGY REQUEST FORMS and other useful information.

**NOTE: The attached *PATIENT CONSENT FOR MICROSCOPIC TISSUE EVALUATION* and *THE MEDICARE OPT-OUT PRIVATE CONTRACT* (if applicable) MUST BE SIGNED by the patient or legally responsible person <u>and</u> it MUST BE ENCLOSED with the specimen to avoid a lab processing delay.**

OPA No. -

LESION LOCATION: ________________

History: ________________

________________

________________

________________

Clinical Appearance: ________________

________________

________________

________________

________________

Radiographic Appearance (submission of radiographs requested): ________________

________________

________________

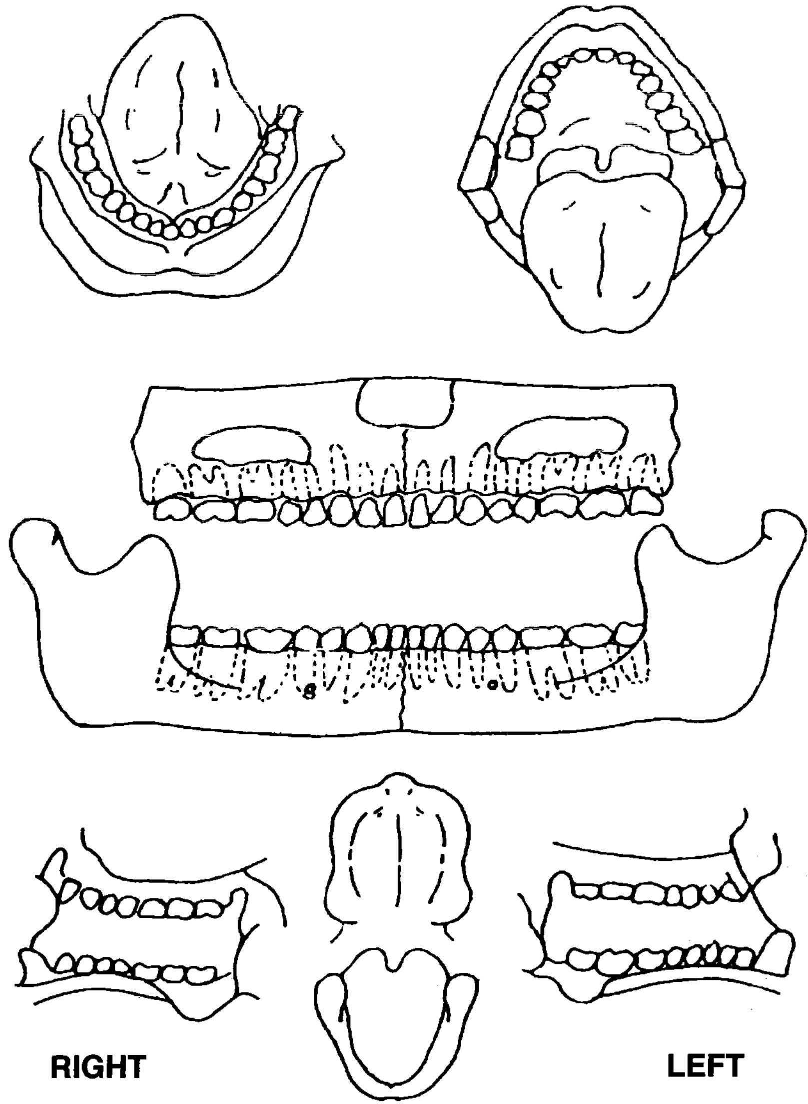
________________

Clinical Impression: ________________

________________

**BIOPSY DATE** ______________ **PATHOLOGY SERVICES REQUESTED BY DR.** ________________

(required) (Doctor signature required)



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# Oral Pathology Associates, Inc.

## MEDICARE OPT-OUT PRIVATE CONTRACT

This contract between Drs. Audrey Boros and/or Raymond Melrose ("Pathologists") and ______________________ ______________________ (Medicare beneficiary or legal representative hereinafter referred to as "Patient") allows Pathologists to provide items or services to Patient without being subject to Medicare limits. Pathologists represent they have opted-out of Medicare and that no Medicare claim will be filed for items or treatment of Patients by Pathologists.

Pathologists represent that they 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 currently facing an emergency or urgent health care situation.

By signing this contract, Patient or legal representative understands and does the following (Initial):

_____ agrees NOT to submit a Medicare claim or ask Pathologists to submit a claim for Pathologists services;

_____ agrees to accept full responsibility for payment of items or services provided by Pathologists and understands that NO REIMBURSEMENT WILL BE PROVIDED UNDER MEDICARE for those items or services;

_____ understands that Medicare payment will not be made for any items or services furnished by Pathologists that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;

_____ acknowledges that MEDICARE LIMITS DO NOT APPLY to amounts Pathologists may charge for such items or services. Patient will pay for such items or services at Pathologists usual rates, in accordance with Pathologists payment policies; and

_____ acknowledges that Medigap 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

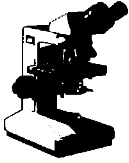
_____ acknowledges that Patient has the right to obtain Medicare-covered items or services by other pathologists or practitioners for whom payment would be made under Medicare. Patient is not required to enter into private contracts that apply to other Medicare covered services furnished by other pathologists who have not opted out.

This contract shall remain in force and effect from the date it is signed by Patient until expiration of the terms of the Pathologists current opt-out period. The expected expiration date of the Pathologist's opt-out period is September 2018 (Dr. Boros) and January 2017 (Dr. Melrose) provided that pathologists may extend the opt-out period further.

I, the Medicare beneficiary or my legal representation have received a copy of this contract before the items or services are provided to me under this contract. If CMS requests a copy of this contract, I authorize a copy to be sent to them.

Accepted and Agreed: ____________________________________________
(Patient or Patient's Legal Representative) Date

Accepted and Agreed: ____________________________________________
(Pathologist) Date



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**DOCTOR: Please have your patient read, sign and date this consent form prior to your biopsy. The completed consent form, and the signed medicare opt out private contract form (if applicable) must be enclosed with the specimen to avoid processing delay. Please give the patient a photocopy of the signed consent(s).**

## CONSENT FOR MICROSCOPIC TISSUE EVALUATION

Your doctor has completed a thorough examination of your mouth and has determined that a biopsy procedure is necessary. The tissue removed during today's surgery will be sent to Oral Pathology Associates, Inc. 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 Maxillofacial Pathologists will fax and mail a written report of the test results to your doctor. Your doctor will discuss the test results with you.**

You will receive a bill directly from Oral Pathology Associates, Inc. for this service, which is separate from the fee charged by your surgeon. Based upon the differing complexities of each tissue sample we receive, our fees may vary. In case of multiple tissue sites, each site will have a separate fee. Decalcification of hard tissue such as bone, evaluation of margins, and special stains entail additional charges.

DO NOT DETACH

As a courtesy to you, we will bill medical or dental insurance companies for our services. We are not members of any preferred provider networks. Therefore, insurance payments are not considered "payment in full". We will request your insurance company to reimburse you directly. Balance in full due within 30 days when you receive the bill regardless of insurance unless special arrangements have been made in advance with our office. **Health Maintenance Organizations (HMO) plans will not cover our charges.** Claims will only be submitted to HMO plans when we have received **prior authorization. We are not providers of any State Benefits Programs or Medicare and have opted out of Medicare. They do not cover our services.** All patients are responsible for payment regardless of insurance. Payments from other types of medical plans vary depending upon your coverage. Should collection action and/or lawsuit be instituted to collect any part of this obligation, the below signatory agrees and promises to pay all collection costs including, but not limited to court costs and attorney fees. We accept payment by Visa or MasterCard.

**In order for Oral Pathology Associates, Inc. to process your biopsy specimen, you must sign and date the statement below.**

Oral Pathology Associates, Inc. has my permission to release medical or other information necessary to submit claims to my insurance company on my behalf. If a financially responsible party has been designated, I authorize Oral Pathology Associates, Inc. to communicate to them information necessary for billing and insurance purposes. I hereby authorize, if applicable, my insurance company to pay benefits directly to Oral Pathology Associates, Inc.

**Our Privacy Commitment to You.** The protected health information your doctor provided to us will be used only for diagnostic, billing, scientific research, 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 or by visiting our website at www.oralpathologyassociates.com

**I have read and understand the above, and consent to microscopic tissue evaluation of this biopsy specimen. I understand that I am responsible for payment for all services provided by Oral Pathology Associates, Inc.**

| ______________________________ | ______________________________ | ______________ |
|---|---|---|
| Signature of Patient, Legal Guardian or Holder of Power of Attorney | Print Name | Date |

**SEE REVERSE SIDE FOR MEDICARE OPT-OUT PRIVATE CONTRACT, TO BE SIGNED BY ALL MEDICARE AND MEDICARE ELIGIBLE PATIENTS.**