WesternU Health
Oral Pathology Laboratory
Web: www.westernu.edu
Email: oralpathology@westernu.edu

PATIENT CONSENT FOR ORAL PATHOLOGY SERVICES

Mark Mintline DDS, Laboratory Director
ABOMP diplomate, AAOMP fellow

ORDERING DOCTOR: Please have your patient read, sign and date this consent form prior to your biopsy or other diagnostic procedure—it must be enclosed with the specimen. Please give the patient a photocopy of this form. Medicare beneficiaries must also sign the Medicare Private Contract attached to this form. Please enclose the original with the specimen and provide a copy to the Medicare beneficiary.

Description of Oral Pathology Services
Your doctor is collecting your tissue specimen(s) and sending them to WesternU Health Oral Pathology Laboratory for histopathologic analysis. A board-certified Oral and Maxillofacial Pathologist will review your specimen(s) to establish a precise diagnosis. Diagnostic reports are usually completed within 24 hours upon receipt, unless the Pathologist determines that additional special tests are needed for diagnosis. The Pathologist will send your report to your doctor, who will discuss the results with you. If your results are serious, the Pathologist will telephone your doctor immediately so that any necessary urgent care can be facilitated.

Separate Billing for Oral Pathology Services
The oral pathology services provided by the Pathologist are separate from the fees charged by your doctor; they are **not** included in your doctor's bill. This means that WesternU Health Oral Pathology Laboratory will send you a separate bill directly and you are solely responsible for paying for the services described in that bill.

The usual fee for our most common routine pathology service is **$320 per specimen**. **However, if the Pathologist determines that additional special tests are necessary to diagnose your case, the cost any such test will be added to our fee.** Payment is due when you receive our bill, and you should pay it promptly to avoid incurring late charges or any interest. We accept American Express, Discover, MasterCard, VISA credit and debit card payments by telephone, fax or mail.

Insurance Not Accepted
WesternU Health Oral Pathology Laboratory is an out-of-network, fee-for-service laboratory that does **not** accept insurance. We do **not** participate as a provider for State-funded plans (such as Medicaid, Medi-Cal/Denti-Cal, AHCCCS), and our Pathologists are "opted-out" of Medicare. When a physician opts-out of Medicare, this means that Medicare does **not** cover services provided by that physician and no Medicare payment can be made to that physician. Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician who has opted out of Medicare.

As a courtesy to you, for certain* PPO medical and dental insurance insurers, we can submit a claim to the insurer for reimbursement to you. Payments from PPO medical and dental insurers vary depending upon your coverage and eligibility of benefits. Again, we do not receive payments from insurers since we are out-of-network. Most insurers will reimburse you directly. If your insurer sends us a payment in error, we will send you a reimbursement to the insured subscriber. A claim will only be submitted when we receive a copy of both sides of your current valid health insurance cards or complete and accurate insurance information on the attached form that is sent to us with your specimen(s).

*Our services are **not** a covered benefit of Kaiser, MetLife, United Concordia and some other plans. In addition, we will not submit claims to Tricare, Veteran Administration and Health Maintenance Organization (HMO) plans (including Kaiser, Medicare, Medi-Cal, Denti-Cal, AHCCCS).

You are responsible for payment for services regardless of insurance.

Medical Information Privacy
The medical information that your doctor provides to us will be used in accordance with applicable Federal and State privacy laws and regulations. Our Notice of Privacy Practices is available by request at oralpathology@westernu.edu.

Consent for Oral Pathology Services
IN ORDER FOR WESTERNU HEALTH ORAL PATHOLOGY LABORATORY TO PROCESS YOUR SPECIMEN(S), YOU MUST SIGN AND DATE THIS CONSENT FORM BELOW.

By signing this form, you are certifying and agreeing as follows:

1. You have read and you understand the information described above and you are acknowledging that you have received a photocopy of this form.
2. You consent to the laboratory tests needed to analyze your specimen(s) and you have been informed that your doctor is sending your specimen(s) to WesternU Health Oral Pathology Laboratory for diagnosis.
3. You agree to be financially responsible for payment of oral pathology services that are needed to diagnose your specimen(s) and you promise to pay for all of the fees charged for oral pathology services, regardless of your medical and/or dental insurance coverage. You agree to pay for all related charges within 30 days of receipt of a bill. You also agree that if your account is transferred to any outside entity for collection, you will pay for the collection agency fee of up to 30% of total charges, reasonable attorney fees and court costs in connection with obtaining payment, to the extent permitted by applicable law.
4. All of your questions regarding your responsibility for payment of pathology services have been answered to your satisfaction. You understand and agree to proceed with the test(s) ordered and related diagnostically indicated services.

Signature of Patient or Responsible Party (legal guardian or holder of power of attorney)	**Print Name / Date of Birth**	**Date**

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Medicare Opt-Out Private Contract

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Section 1802 of the Social Security Act, as amended by §4507 of the Balanced Budget Act of 1997 and §106 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10), permits a physician to opt-out of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements are met. A physician who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services.

This Medicare Opt-Out Private Contract ("**Contract**") is made and entered into by and between Dr. Mark Mintline ("**Pathologist**") and _____ (the Medicare beneficiary or his/her legal representative, referred to in this Contract as "**Patient**"). This Contract allows Pathologist to provide oral pathology services to Patient without being required to submit claims to Medicare for such services and without being subject to Medicare limits on charges for such services.

Pathologist (NPI _____) has not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act.

By signing this Contact, Patient agrees to the following:

1. Patient shall accept full responsibility for payment of charges for all services furnished by Pathologist.
2. Patient understands that Medicare limits do not apply to what Pathologist may charge for items or services furnished.
3. Patient agrees not to submit a claim to Medicare or to ask Pathologist to submit a claim to Medicare.
4. Patient understands that Medicare payment will not be made for any items or services furnished by Pathologist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
5. Patient enters into this Contract with the knowledge that Patient has the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
6. The expected or known effective date and expected or known expiration date of the opt-out period is _____ (effective date) and _____ (expiration date).
7. Patient understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
8. This Contract cannot be entered into by Patient during a time when Patient requires emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual.)
9. Patient will receive or have received a copy (a photocopy is permissible) of this Contract, before items or services are furnished to me under the terms of this Contract.

WesternU Health

Medicare Opt-Out Private Contract

Pathologist agrees to the following:

1. Pathologist has submitted an affidavit to Medicare expressing his/her decision to opt-out.
2. Pathologist will retain the original Contract (original signatures of both parties required) for the duration of the opt-out period.
3. Pathologist will supply CMS with a copy of this Contract upon request.
4. Pathologist understands that the current private contract remains in effect for two years. If Pathologist again opts-out of Medicare, Pathologist will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Patient and Pathologist have executed this Contract on the date set forth below.

_____	_____	_____
Signature of Patient/Legal Representative	**Print Name**	**Date**
_____	_____	_____
Signature of Pathologist	**Print Name and NPI**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**

Patient's Contact Information

Contact Name: _____

Email: _____

Phone: _____

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Lab use only
Postdated:
Accession #:
Received:

Mark Mintline DDS, Laboratory Director
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Tissue examination request (1/2)

REQUESTING DOCTOR

Doctor's name *(Please print.)* Specialty

Address

City State Zip

Telephone Fax

License number NPI

Email

PATIENT INFORMATION

Patient name *(Please print.)* Social security number

Date of birth (MM/DD/YYYY) Age Sex

Address

City State Zip

Home telephone Work or mobile telephone

Email

☐ Asian ☐ Black ☐ Hispanic ☐ Indian ☐ White ☐ _____ Other

PLEASE REVIEW

This lab is not a contracted provider for State-Funded Plans (Medicaid, Medi-Cal, Medi-Cal Dental). Currently, the laboratory does not accept any forms of insurance.

All Medicare patients must complete, sign, and date the attached Medicare Opt-Out Private Contract before their specimen will be processed. Missing signatures will delay specimen processing and diagnosis.

The Patient Consent for Tissue Examination and The Medicare Opt-Out Private Contract must be signed by the patient or legally responsible person and must be enclosed with the specimen prior to lab processing and diagnosis.

SEND BILL TO

☐ Patient listed above

☐ Financially responsible person
(if above patient is under age 18)

Name *(Please print.)* Relationship to patient

Address

City State Zip

PLEASE NOTE: California laboratories cannot bill doctors (CA Business & Professions Code 655.7)

BIOPSY KITS

Please send ____ formalin bottles and forms.

WesternU Health

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Web: www.westernu.edu
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Lab use only
Report sent: **Accession #:**
Initial:

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Tissue examination request (2/2)

PATIENT NAME

(Please print.)

_____

BIOPSY COLLECTION DATE

____ / ____ / _____

Prior lab test results

_____

RELEVANT CLINICAL INFORMATION

Biopsy location: _____

_____

Clinical information/diagnosis and history: _____

_____

_____

_____

Radiographic findings: _____

_____

Clinical impression/differential diagnosis:_____

_____

_____

Other:_____

_____

RADIOGRAPHS AND CLINICAL PHOTOGRAPHS

Please include radiograph if lesion involves bone.

☐ Radiograph sent ☐ Clinical photo sent

LABORATORY USE ONLY

DOCTOR SIGNATURE REQUIRED

Dr. _____

Fax:_____

SERVICE TYPE

☐ Excisional biopsy
☐ Incisional biopsy
☐ Direct immunofluorescence (DIF) : Michel's / Zeus' medium
☐ Smear/aspiration

☐ Consultation on outside slides
☐ Other _____

REPORT PRIORITY

Post-op date _____ / _____ / _____ Time _____

BIOPSY LOCATION (Use appropriate figure(s) below.) PLEASE ALSO INCLUDE WRITTEN DESCRIPTION.