Patient Acknowledgement Form

INFORMATION FOR THE PATIENT
The UCLA ORAL PATHOLOGY LABORATORY provides Oral and Maxillofacial Pathology services to doctors in California and throughout the nation. We provide direct service and also serve as consultants to other doctors and laboratories. Our doctors are all Board Certified with many years of experience.

You can find out more about us, find answers to frequently asked questions and HIPAA information on the web at www.dent.ucla.edu/oralpathlab

MICROSCOPIC TISSUE EVALUATION
Your doctor has explained that a biopsy procedure of your mouth, jaw or facial region is indicated. Your tissue sample will be sent to the UCLA ORAL PATHOLOGY LABORATORY for examination and diagnosis. We will mail a report to your doctor who can discuss the results with you. Your signature, below, confirms your acknowledgment that your doctor has ordered oral pathology services to be performed on your behalf.

ELECTRONIC TRANSMISSION OF CLINICAL INFORMATION
We may need to communicate with your doctor regarding other information including: radiographs, additional clinical information, clinical photos, photomicrographs and reports from other doctors.

BILLING
You will receive a bill from our billing service, Orion Rand Medical Billing. Our billing service can be contacted at 805-578-8300. If the doctor who performed the biopsy provides us with your billing information, our billing service will bill medical or dental insurance as a courtesy to you.

We are Medicare providers. If you are Medicare-eligible, we cannot process your specimen unless your doctor is registered with Medicare (PECOS). Your doctor may be registered as “Prescribed refer” or “Opt-out”. If you are Medicare eligible, inform your doctor and provide your doctor with your Medicare number or a copy of your Medicare card and your date of birth. Note that some oral biopsies are NOT Medicare covered services.

We are not members of any Preferred Provider network. HMO plans (including Medicare HMO) require prior authorization. You are responsible for payment in full of our services. You are also responsible for any legal or collection agency fees that we may institute to collect timely payment of this obligation.

My signature below represents my acknowledgment that I have read and understand the foregoing information.

______________________________________________________________  ______________
Signature of Patient, Legal Guardian or Holder of Power of Attorney  Date

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Printed name of Signatory

DOCTORS: Please return the original of this form with the specimen. Thank you.