PLEASE RETURN TOP COPY. TYPE OR PRINT NEATLY AND FILL OUT COMPLETELY.

Surgery Date ____/____/____

PLEASE MARK SERVICES REQUESTED

❑ Report Only ❑ Slide & Report ❑ Slide Only ❑ Margins ❑ Consult

Please submit copy of facesheet if available

Patient _____
Last Name First MI

Address _____
Street City State Zip

Date of Birth ____/____/____ Sex ❑ Female ❑ Male Race _____

SS# _____ - _____ - _____ Phone (____) _____

IF INSURANCE IS TO BE BILLED, PLEASE ATTACH A LEGIBLE COPY OF THE FRONT AND BACK OF ALL MEDICAL INSURANCE CARDS, INCLUDING MEDICARE AND MEDICAID.

ACCOUNT LIABILITY & RECORDS RELEASE AUTHORIZATION In consideration of the services rendered or to be rendered by Cutaneous and Maxillofacial Pathology Laboratory (CAMP Lab) the undersigned, whether signing as patient or patient's agent, agrees to assume all liability and payment for the patient's account according to the rates and charges of CAMP Lab. I understand that my insurance, including Medicare, may or may not cover the service and assume liability for all charges not paid by my insurance. I request that payment of authorized Medicare, Medigap, or any other insurance be made either to me or on my behalf to CAMP Lab for any services furnished by CAMP Lab. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I consent to the use of the specimen procured for research purposes. The undersigned also agrees that if the unpaid balance is referred to a debt collection agency, you will be responsible for any interest that can be added at the current legal rate as well as collection fee charges and reasonable attorney fees/court costs (if applicable).

Signature of Patient/Parent/Guardian (required) _____

Printed Name of Physician **(required)** _____

Signature of Physician **(required)** _____

CAMP LABORATORY

CUTANEOUS AND MAXILLOFACIAL
PATHOLOGY LABORATORY, PC
9292 N. Meridian St., Suite 210
Indianapolis, Indiana 46260
(317) 843-2204
Fax: (317) 843-2478

LAB USE ONLY

Biopsy Method: ❑ Punch ❑ Incision ❑ Excision ❑ Shave ❑ Curettement ❑ Enucleate ❑ Extraction ❑ Other _____

Site & Size of **Entire** Lesion _____

History and Impression:

LAB USE ONLY Use back for additional information

__00 __04 __05 __07 __09 __11 __12 __13 __21 __23 __42 __65-26

ICD10 _____ Total Charge _____