Please have patient sign informed consent and HIPAA release on reverse. Specimens cannot be processed without patient's signature. Please complete patient information for billing purposes. If filing with insurance include a copy of patient's drivers license and insurance card.

PATHOLOGY

Biopsy Date: / /

Side
□Right □Left □Midline

Inside Bone (incudes periapical area)

□Maxilla
□Mandible
□Maxillary sinus
□Hard palate

Specifier
□Anterior
□Posterior
□Associated with impacted tooth

Outside bone (from soft tissue)

Tongue
□Dorsal
□Lateral
□Ventral
□Frenum
□Lingual tonsil

Alveolar ridge
□Maxillary
□Mandibular

Vestibule
□Maxillary
□Mandibular

Gingiva
□Maxillary
□Mandibular

Buccal mucosa
□Anterior
□Posterior
□Mid
□Stensen's duct

Floor of mouth
□Anterior
□Posterior
□Wharton's duct

Lip
□Upper
□Lower
□Vermilion
□Wet/dry line
□Commissure

Palate
□Hard
□Soft

Other
□Faucial Pillar
□Retromolar pad
□Uvula
□Pterygomandibular raphe
□Skin
□Tuberosity
□Nasal cavity

Specifiers (check all that apply)
□Anterior □Facial
□Posterior □Lingual
□Frenum

Patient Information:
Last name:
First name:
Patient ID (if applicable):
Social security number: - -
□Male □Female DOB: / /
Address:
City: State:
Zip:
Telephone #:

Doctor Information:
(or attach business card)
Last name:
First name:
Address:
City: State: Zip:
Telephone #:
NPI#:

Description of lesion:

Clinical
□Erythematous
□Leukoplakic
□Papillary
□Indurated
□Ulcerated
□Reticulated

Radiographic
□Radiolucent
□Radiopaque
□Mixed lucent/opaque
□Well-circumscribed
□Poorly circumscribed
□Moth-eaten

History:

Clinical Diagnosis:

Submitting Doctor's Signature:_____Date:_____

JKJ Pathology 4223 Research Forest Dr., Ste 500 The Woodlands, TX 77381
johnkacher@jkjpathology.com www.jkjpathology.com
(T) 281-292-7954 (F) 281-292-7372

PATHOLOGY

Oral Medicine ● Oral Pathology

Patient Authorization

I consent to having my biopsy specimen(s) examined microscopically by a pathologist for the purpose of disease detection and diagnosis. I authorize the release of my medical or other information necessary to process my insurance claim or in communication as deemed necessary with the referring doctor or consulting doctors.

I understand that JKJ Pathology is an outside service that will interpret my biopsy specimen and issue a pathology report to the doctor that performed the biopsy procedure. The fee for this service is not included with the cost of the biopsy procedure itself.

JKJ Pathology will file an insurance claim with my medical insurance carrier and then bill me directly for any fees not covered by the insurance company for this service. The rate of insurance coverage varies by plan, deductible, spending limits, and other factors that are part of my insurance plan. The pathology fee may vary based on differing complexity of the tissue sample received. Decalcification of bone and special stains entail additional charges.

As such, I am financially responsible for the balance on my account with JKJ Pathology and will be billed directly for this balance, separate from my surgical fees. All patients are responsible for payment regardless of insurance coverage. I am aware that past due accounts will be submitted to a collection agency. I will also be responsible for collection costs and/or attorney fees. **We are not providers of any State Benefit Programs or for Medicare. They do not cover our services. Claims for Medicare beneficiaries will be submitted for secondary insurance coverage, if available.**

In order for JKJ Pathology to process your biopsy specimen, you must sign and date the statement below.

I have read and understand the above and consent to microscopic tissue evaluation of this biopsy specimen.

_____

Patient name or Legal Guardian Date

_____

Patient Signature

JKJ Pathology 4223 Research Forest Dr., Ste 500 The Woodlands, TX 77381
johnkacher@jkjpathology.com www.jkjpathology.com
(T) 281-292-7954 (F) 281-292-7372