



PATIENT CONSENT FOR PATHOLOGY SERVICES

Please - forward white original to LAB - retain yellow copy - pink copy to patient

1. A fee for service will be rendered for this diagnostic procedure(s) which is **separate from the fee charged by your clinician** (medical or dental) surgeon. Depending on the differing complexities of each tissue sample we receive, our fees may vary based on CPT codes, but are within the usual & customary fees for this region.

Please sign and date the statement below.

2. **Office Policy: In order for LMC Pathology Lab to process your biopsy specimen, perform microscopic analysis and generate a pathology report; we require your authorization.**

- ✓ We courtesy submit your claim electronically to the insurance company of your choice. Upon receipt of an EOB, you will receive an invoice from us. **Payment balance (if any) is due upon receipt. If self-pay please provide credit card info.**
- ✓ Coverage & reimbursements vary depending on the insurance company & plan. HMO plans will not cover charges unless prior authorization is obtained. **We are not members of any preferred provider networks except Medicare and bill 15% above Tricare allowable.** It is the patient's responsibility to contact their insurance company to determine if they have out of network provisions.
- ✓ Failure to pay or communicate with our office (i.e. payment plan) after 2 billing cycles may result in collections agency assistance. Collection fees, overdrawn check charges and or interest for unpaid balances over 90 days (18% APR-1.5% monthly) and attorney fess may be added to your original fee for service.
- ✓ You can elect to pay by credit card (fill in the appropriate information on the invoice you will receive). Your credit card may be charged for any balance due after 60 days.
- ✓ Out of state submissions will incur shipping costs.

3. I understand that under the Health Insurance Portability & Accountability Act (HIPAA) of 1996 that I have certain rights to privacy regarding my protected health information. Lightmic Consulting, LLC has my permission to

- ✓ Release medical or other information necessary to submit claims to my insurance company on my behalf in order to obtain payment from third party payers.
- ✓ Conduct analysis of diagnostic material(s) and request, perform additional studies as needed, as well as review by other healthcare providers (2nd opinion consultation), quality assessment (peer review), and electronic transfer of your biopsy report to your doctor or appropriate staff.

4. LMC's legal duty, as applicable by federal & state law is to maintain privacy of your health information. The organization also has the right to change it's Notice of Privacy Practice from time to time and to follow those privacy notices that are in effect.

5. I understand that I am responsible for payment for all services provided by Lightmic Consulting, LLC, Pathology and Forensics.

6. **By signing below, you are indicating you have read , understand and agree with this contract**

Patient/responsible person signature if under 18	Date	Patient Name (print)

Clinical: 243 Church St. NW, suite 200 A, Vienna VA 22180

Correspondance: PO Box 568, Vienna, VA 22183

Billing inquiries - (703) 242-5639, lmdxpathbill@aol.com

Dr Arendt direct (703) 281-5970 - (703) 281-6970 (fax) lightmic@aol.com www.lightmicron.com