



<u>PATIENT REFERRAL – CONSULT REQUEST</u>	Date Received _____
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Requesting Doctor	Doctor	Patient	Last Name	First name	Initial	
	Address		Patients Address			
	City		State & Zip	City		State & Zip
	Phone		Fax	Home Phone	Work Phone / email	
	NPI #		email	SSN	Age	DOB
	<u>Pharmacy</u> contact info			<u>Physician</u> contact info:		

CHIEF COMPLAINT - SYMPTOMS

Location of lesion(s) or process:	Bx Date:
Date of last physical exam?	Date last lab (blood tests)
History & Clinical Information	
Clinical Impression	Have X-rays been forwarded?

1. PLEASE FORWARD A COPY OF THE PATIENTS MEDICAL INSURANCE INFO PRIOR TO THEIR EXAM.
2. CC info will be required at the time of their appointment. Their CC will be debited upon completion of the exam based on CPT codes for services generated.
3. Subsequent to receipt of the EOB from their insurance company or payment, if there is a balance due it will be reimbursed within 10 business days (please review the pathology consent form)

Insurance Plan Name	Name of Subscriber	Relation to Patient: _____Self _____Spouse _____Child
Insurance Plan Phone #	Subscriber ID #	Group or Policy #
Credit Card info: Visa/ MC	#	billing zip code

Private Insurance Authorization for assignment of Benefits / Information Release

I, the undersigned authorize payment of medical benefits to Lightmic Consulting, LLC for any services furnished to me by the clinician. Lightmic Consulting, LLC will courtesy submit to your insurance company. I understand that I am financially responsible for the amount not covered by my contract. I also. authorize you to release to my Insurance company or agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

➔ Patient signature: (parent or guardian if for dependent under 18 years of age)