



TISSUE EXAMINATION REQUEST FORM

2904 Westcorp Blvd., Suite 107, Huntsville, AL 35805 (256) 533-1480

Medical Directors:
 Walter G. Grundy, M.D. Cheryl M. Kirk, M.D.
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 J. Craig Romer, M.D. Aimee' A. League, M.D.
 Mark W. Teague, M.D. L. Allen Perkins, M.D.
 Kathryn L. Lane, M.D. Carrie S. Knight, M.D.
 Priya S. Gore', M.D. William K. Brix, M.D.

PATIENT NAME (LAST, FIRST, MIDDLE)				
PATIENT SOCIAL SECURITY # - -		DATE OF BIRTH	AGE	SEX
PATIENT PHONE # ()		CHART/PATIENT ID#		
PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT				
STREET ADDRESS OF INSURED/RESPONSIBLE PARTY				
CITY	STATE	ZIP		

DATE COLLECTED	TIME	A.M. P.M.
REFERRING PHYSICIAN / NPI		

SOURCE OF SPECIMEN: _____

FROZEN SECTION DX: _____

REQUIRED BILLING INFO...ATTACH COPY OF INSURANCE CARD(S)

HISTORY AND CLINICAL DX: _____

PATIENT SIGNATURE REQUIRED

I authorize the release of any medical and insurance information about me to insurance carriers involving claims made for the services requested by my physician. I understand that these services will be billed separately by the provider. Unless covered by Medicare, Medicaid, or carrier for which the provider has agreed to accept payment in full, I agree to be responsible for payment in full within thirty days of receiving a statement, and to pay any additional fees to collect payment, even if my insurance is filed, or if my insurance decides that these services are "not reasonable or medically necessary".

_____ Date _____ Patient's Signature

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