UC DAVIS DERMATOPATHOLOGY SERVICE

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MAXWELL A. FUNG, MD, LABORATORY DIRECTOR
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CLIA ID# 05D1021511
CA LICENSE ID#CLM 331466

SUBMITTING PHYSICIAN:

Phone: Fax:

ADDITIONAL COPIES TO:

Phone: Fax:

PATIENT DATA:

NAME: (LAST) (FIRST) (M)

DATE OF BIRTH: MALE ☐ FEMALE ☐

SSN#:

ADDRESS & ZIP CODE:

PHONE: (HOME) (WORK)

INSURANCE DATA (OR INCLUDE COPY OF CARD):

*****(PLEASE SIGN REVERSE)**

BILL: ☐Patient ☐Insurance ☐Other (specify)

Primary carrier:
ID/Group#:
Billing address:

Patient's relationship to Subscriber: self _____

Secondary carrier:
ID/Group#:
Billing address:

Patient's relationship to Subscriber: self _____

DATE OF SERVICE:_____**(TIME)** **PREVIOUS BIOPSY?**_____

SPECIMEN TYPE (CIRCLE)

A) **BIOPSY** ☐SHAVE ☐PUNCH ☐ALOPECIA (trans sect) ☐INCISIONAL (long sect) ☐**SHAVE REMOVAL** (CHECK MARGINS) ☐**EXCISION** (CHECK MARGINS) PUNCH / ELLIPTICAL ☐**SLIDE CONSULTATION (attach prev path report)** ☐**DIRECT IMMUNOFLUORESCENCE**	**SITE**	**CLINICAL DIAGNOSIS / DESCRIPTION**
B) **BIOPSY** ☐SHAVE ☐PUNCH ☐ALOPECIA (trans sect) ☐INCISIONAL (long sect) ☐**SHAVE REMOVAL** (CHECK MARGINS) ☐**EXCISION** (CHECK MARGINS) PUNCH / ELLIPTICAL ☐**SLIDE CONSULTATION (attach prev path report)** ☐**DIRECT IMMUNOFLUORESCENCE**	**SITE**	**CLINICAL DIAGNOSIS / DESCRIPTION**
C) **BIOPSY** ☐SHAVE ☐PUNCH ☐ALOPECIA (trans sect) ☐INCISIONAL (long sect) ☐**SHAVE REMOVAL** (CHECK MARGINS) ☐**EXCISION** (CHECK MARGINS) PUNCH / ELLIPTICAL ☐**SLIDE CONSULTATION (attach prev path report)** ☐**DIRECT IMMUNOFLUORESCENCE**	**SITE**	**CLINICAL DIAGNOSIS / DESCRIPTION**
D) **BIOPSY** ☐SHAVE ☐PUNCH ☐ALOPECIA (trans sect) ☐INCISIONAL (long sect) ☐**SHAVE REMOVAL** (CHECK MARGINS) ☐**EXCISION** (CHECK MARGINS) PUNCH / ELLIPTICAL ☐**SLIDE CONSULTATION (attach prev path report)** ☐**DIRECT IMMUNOFLUORESCENCE**	**SITE**	**CLINICAL DIAGNOSIS / DESCRIPTION**

(USE ADDITIONAL SHEETS IF NECESSARY)

LAB USE ONLY:

☐ PAYMENT BY HEALTHCARE PLAN:

I hereby authorize and direct my healthcare plan to pay **University of California Davis** for services rendered in my behalf by **UC Davis Dermatopathology Service.** I further agree to and accept full financial responsibility for payment of charges rendered to me under the rules of my healthcare plan. I authorize the release of any medical information pertaining to the examination of the specimen(s) to: (1) the referring physician or (2) necessary to process the claim.

In accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards, the University of California Davis Health System (UCDHS) has developed a brochure entitled "Notice Of Privacy Practices" that is available on request and at www.ucdermpath.org.

Signature of Patient or Legal Representative

Date

OR

☐ COSMETIC / OUT OF POCKET:

I hereby authorize **UC Davis Dermatopathology Service** at **University of California Davis** to perform the requested services on my behalf. I further agree to and accept full financial responsibility for payment of charges rendered to me **as explained by my doctor/provider**:

I also authorize the release of any medical information pertaining to the examination of the specimen(s) to the referring physician.

In accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards, the University of California Davis Health System (UCDHS) has developed a brochure entitled "Notice Of Privacy Practices" that is available on request and at www.ucdermpath.org.

Signature of Patient or Legal Representative

Date