



Associated Pathology Medical Group

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WOMEN'S HEALTH/BIOPSY
Cytology/Histology

PATIENT INFORMATION

CLIENT INFORMATION

Last Name		First Name		M.I.
Date of Birth	Sex M F	Specimen Date / /		
Patient Social Security Number		Patient Phone Number		
Street Address			Apt. #	
City		State	Zip	

Special Handling
 Phone Fax (____) _____ CC _____ Physician's Signature _____

BILLING INFORMATION Attach copy of all insurance I.D. cards (front and back, please)

Bill To: Patient Doctor HMO Insurance Medicare/Medi-Cal # _____

Subscriber Name _____ Relationship to Subscriber: Self Spouse Dependent Other _____

Insurance Name _____ Address _____ City, State, Zip _____

ID # _____ Group # _____

Subscriber DOB: _____ Subscriber Sex: Male Female

Medicare patient reviewed and signed advanced beneficiary notice for non-covered services

ICD-9 Code (Required) Routine High-Risk Diagnosis Code(s) _____

GYN CYTOLOGY

Pap Test: (See Supplies For Specimen Info)

ThinPrep® Pap, reflex HPV on ASC-US and above*
 ThinPrep® Pap, reflex HPV on ASC-US only*
 ThinPrep® Pap with HPV* (FDA approved for women 30+)
 ThinPrep® Pap only
 HPV only (no Pap)* **Both high and low-risk probes will be performed. If high-risk probe only, please check here:*
 Conventional Pap

Tests from ThinPrep® vial Digene / Swab Kit

Chlamydia and Gonorrhea
 Chlamydia only
 Gonorrhea only

Tests from BD AFFIRM VPIII Kit:

Candida
 Trichomonas
 Gardnerella

SPECIMEN SOURCE: Cervical/Endocervical Cervical Vaginal Other _____

CLINICAL INFORMATION

Last Menstrual Period: ____/____/____

Routine Check-up Postmenopausal Depo Provera Abnormal Bleeding
 Repeat/Follow-up Total Hysterectomy Hormonal Replacement Therapy Previous Malignancy/Type
 Pregnant (wks. ____)
 Sub-total Hysterectomy (cervix present) IUD Radiation/Chemotherapy
 Postpartum (wks. ____)
 Oral Contraceptives HPV/LGSIL/HGSIL Immunosuppressed
 Cryo/Laser/LEEP/Cone Other _____

PREVIOUS	PAP	BIOPSY
Date		
Accession No./Lab		
Diagnosis		

HISTOLOGY (TISSUE BIOPSIES)

Clinical History / Clinical Diagnosis:

NON-GYN CYTOLOGY

Specimen Source:

URINE: Voided Cath Bladder Wash
 UroVysion™

Sputum
 Nipple Discharge
 Body Cavity Fluids (specify source) _____
 Fine Needle Aspiration (specify source) _____
 Other (specify) _____

No. of Smears: Air Dried _____ Fixed _____

Tissue Submitted (list site)

Cervix _____
 LEEP _____
 ECC _____
 Endometrium _____
 POC _____
 TAB _____
 Skin Tag _____
 Other _____

Patient's Name: _____ Medicare #: _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests
Pap Tests		

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (**Estimated Cost: \$50-\$100**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES I want to receive these laboratory tests.

I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO I have decided not to receive these laboratory tests.

I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I will notify my doctor who ordered these laboratory tests that I did not receive them.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.