Tufts UNIVERSITY | School of Dental Medicine

Tufts Oral Pathology Services
Expert & Convenient
Biopsy Services

PATIENT INFORMATION & CONSENT FORM

Information for Patients Undergoing Diagnostic Tests

In conducting your oral examination, your doctor has determined that a biopsy or cytology procedure should be performed. Your doctor will send your specimen to Tufts Oral Pathology Services, where it will be analyzed by our board-certified pathologists on the faculty of Tufts University.

Along with your specimen, your doctor will supply copies of your records and MEDICAL (not dental) insurance card(s). This will facilitate the processing of your insurance claim, which Tufts will submit to your medical insurance for payment of fees related to analysis of your specimen. (Please note that Tufts Oral Pathology Services' fees are separate from your doctor's fees for performing the biopsy.)

Pathology costs vary based on the complexity of each specimen, and your coverage depends on your individual insurance plan. Particularly complex cases may be sent in consultation to sub-specialists at outside institutions. If you are responsible for a co-payment or deductible, or if your medical insurance does not cover all of the pathology costs, you will be contacted by the billing department at that time.

If you have any questions about the status of your insurance claim or payment, please call Tufts University School of Dental Medicine's billing department at 617.636.6986 (select option #5).

Tufts Oral Pathology Services will analyze your specimen with extreme care and will send the results to your doctor.

Patient Consent and Acceptance of Financial Responsibility

I authorize my doctor to send my specimen, medical insurance information, and other relevant records (including photographs and/or radiographs) to Tufts Oral Pathology Services. I hereby give my consent to Tufts Oral Pathology Services to analyze my specimen and submit a claim to my medical insurance carrier on my behalf.

I understand that I am responsible for paying any fees that are not covered by my medical insurance.

Patient or Parent/Guardian:

Name: _____

Signature: _____ **Date:** _____

(For patients under age 18, please include contact information of parent/guardian)

Street address: _____

City/State/ZIP: _____ **Phone:** _____

Please return white copy of form to your doctor and keep yellow copy for your records.

TU-B0068 Rev 08/2021 Reorder Copy Center 6-5373