RUTGERS
School of Dental Medicine

Rutgers University Diagnostic Services
P.O. Box 1709, 110 Bergen Street, D860
Newark, New Jersey 07103
Billing Inquiries: (973) 972-4603
All other Inquiries: (973) 972-1646
FAX: (973) 972-3164

DOCTOR: Please have your patient read, sign and date this consent form prior to your biopsy. The completed form must be enclosed with the specimen. Please make a photocopy of this signed form for your patient.

PATIENT: A notice of our privacy practices may be found on the reverse.

CONSENT FOR MICROSCOPIC TISSUE EVALUATION

Your doctor has done a thorough examination of your mouth and has determined that you need to have a biopsy procedure performed. The tissue removed during today's surgery will be sent to the Rutgers University Diagnostic Services for microscopic examination and diagnosis. Your doctor is ensuring your good health by making sure that any abnormal tissue removed is examined microscopically so that a definitive diagnosis can be made and the correct treatment rendered. Our board-certified Oral and Maxillofacial Pathologists will fax and/or mail a written report of the test results to your doctor. Your doctor will discuss the test results with you.

You will receive a bill directly from Rutgers University Diagnostic Services for this service, which is separate from the fee charged by your surgeon. Based upon the differing complexities of each tissue sample we receive, our fees may vary. In case of multiple tissue sites, each site will have a separate fee. Decalcification of hard tissue such as bone and special stains entail additional charges.

We do not submit claims to private insurance companies on your behalf; however, we are a Medicare and traditional Medicaid provider. Payment is due when the bill is received. For your convenience, we accept a number of different credit cards.

In order for Rutgers University Diagnostic Services to process your biopsy specimen, you must sign and date the statement below.

I have read and understand the above, and consent to microscopic tissue evaluation of this biopsy specimen. I understand that I am responsible for payment for all services provided by Rutgers University Diagnostic Services.

Rutgers University Diagnostic Services has my permission to release medical or other information necessary to submit claims to my insurance company on my behalf. If a financially responsible party has been designated, I authorize Rutgers University Diagnostic Services to communicate to them information necessary for billing and insurance purposes. This consent will be valid for one year from the date of signed.

_____	_____	_____
Signature of Patient, Legal Guardian or Holder of Power of Attorney	Print Name	Date