COFFEE REGIONAL
MEDICAL CENTER
912–384–1900
Ext 4140
Gerson Paull, M.D., Laboratory Director
1101 Ocilla Road, Douglas, GA 31533

HISTOLOGY REQUEST

Patient Name: ______________________ DOB: ____________ Sex: ____________

Outpatients please complete below:

Address: ______________________

Phone #: ______________________ SS#: ______________________

Name of Contact Person: ______________________ Contact Phone #: ______________________

Contact Address: ______________________

Primary Insurance & #: ______________________

Secondary Insurance & #: ______________________

Name of Insured: ______________________ SS # of Insured: ______________________

PLEASE ATTACH FRONT AND BACK COPY OF INSURANCE CARD

****** Outpatients must sign the back of this form. ******

Date/Time: ______________________

Submitting Physician: ______________________

Attending Physician: ______________________

Priority: ______________________

Specimen Source (Please label each tissue container):

(A) ______________________ (D) ______________________

(B) ______________________ (E) ______________________

(C) ______________________ (F) ______________________

Pertinent Clinical History: ______________________

IMPORTANT:

Does this patient have a history of cancer? ❑ Yes ❑ No

If yes, what type: ______________________

Does this patient have a history of radiation therapy? ❑ Yes ❑ No

Does this patient have a history of chemotherapy? ❑ Yes ❑ No

LABORATORY USE ONLY

Accession # ______________________

Physician Offices–
For the most updated form please visit www.coffeeregional.org and print from the "For Our Physicians" link.

Physician Signature ______________________ Date/Time ______________________

COFFEE REGIONAL
MEDICAL CENTER

HISTOLOGY REQUEST

Patient's Name: _______________________________ Date of Birth: _______________ SSN: ______________________

Emergency Contact:____ Phone: ________________________

I authorize consent for Coffee Regional Medical Center (CRMC) to perform diagnostic testing and authorize CRMC to release any medical information and documents to Blue Cross Blue Shield, Medicare, Medicaid or other insurance companies for the purpose of completing an insurance claim. I hereby assign to and authorize the direct payment to Coffee Regional Medical Center of any and all insurance or other benefits payable to me for any services rendered. I acknowledge that I am solely responsible for any charges incurred for services provided by Coffee Regional Medical Center. I accept full responsibility for all charges not covered by insurance of for which payment is denied.

I authorize Coffee Regional Medical Center, its service providers (including service providers contacting me about obtaining potential financial assistance for my accounts(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my accounts(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using pre-recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

Additional Provision for Minors: I acknowledge and verify that I am the legal guardian or custodian of minor/incapacitated patient and can legally give legal consent under Georgia Medical Consent Law.

HIPAA Consent/Privacy Notice:
I understand that Coffee Regional Medical Center will use and disclose protected health information about me as a patient or about the patient on whose behalf I am giving this consent to carry our treatment, payment or health care operations and will limit other disclosures as described in the Notice of Privacy Practices ("Notice") of coffee Regional Medical Center. I understand that I have the right to receive a paper copy of this notice upon request by calling (912) 384–1900 ext. 4549 or by visiting our Web Site www.coffeeregional.org.

INDEPENDENT CONTRACTORS: Some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omission of any such independent contractors.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

Date:_______________ Time:______________ AM / PM

____ (SEAL) ____________________ ____________________
Patient /Guarantor /Authorized Person Signature Relation to Patient Patient Phone Number

Company / Agency____Phone Number____________________

Employee Witness____ Title____________________________