

PATHOLOGY CONSULTATION International Patients Billing Information

PATIENT DEMOGRAPHIC

(Please complete this form and return along with related Pathology report (s) and material (s)

Patient's Name (s) and Date of Birth must match report (s) and appear as entered on legal documents such as passports and/or driver's license. Copies of legal documents are also helpful.)

NOTE: INCOMPLETE PATIENT OR BILLING INFORMATION WILL DELAY PROCESSING OF YOUR REQUEST

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
ADDRESS:				
CITY:	STATE/COUNTRY:		ZIP/COUNTRY CODE:	
PHONE:	FAX:		EMAIL:	
Date of Birth: Month/Day/Year	MARITAL STATUS: Married <input type="checkbox"/> Single <input type="checkbox"/>		GENDER: Male <input type="checkbox"/> Female <input type="checkbox"/>	

PHYSICIAN

(Please provide complete mailing address of physician in which to forward patient report)

NAME:		
SPECIALTY:		
ADDRESS:		SUITE:
CITY:	STATE/COUNTRY:	ZIP/COUNTRY CODE:
PHONE:	FAX:	EMAIL:

Financial Obligations

Below are the services that we provide, along with the estimated minimum cost. **Important:** Please understand that the review cannot be processed without the credit card payment information. By providing this information, you are authorizing us to post charges to your credit card (s) without us having to provide you with advanced notification of charges being made.

Service

Reading of pathology materials by a pathologist, with typed report.

Estimated Cost

Minimum \$525 / as high as (but not limited to) **\$4000 +** the materials provided for review. It is not possible to know the actual total cost before finalizing the review.

BILL CREDIT CARD (*American Express, Visa, MasterCard, and Discover accepted*)

TYPE:	CARD NUMBER:	EXPIRATION DATE:
CARD HOLDER'S NAME:	Name should be entered as it appears on card <i>I authorize MD Anderson Cancer Center to charge the above credit card for this consultation</i>	
CARD HOLDER'S SIGNATURE:		
ALTERNATE CREDIT CARD		
TYPE:	CARD NUMBER:	EXPIRATION DATE:
CARD HOLDER'S NAME:	Name should be entered as it appears on card <i>I authorize MD Anderson Cancer Center to charge the above credit card for this consultation</i>	
CARD HOLDER'S SIGNATURE:		