bach diagnostics
passion, science, care

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1. PRACTICE INFORMATION: Name, Address, Phone Number

2. PATIENT INFORMATION

LAST NAME: FIRST: MI:

Sex: ☐ Male ☐ Female

DOB:

SSN:

PATIENT ADDRESS & PHONE: ☐ See Attached

3. SPECIMEN INTAKE DETAILS

COLLECTOR'S NAME:

DATE COLLECTED:

TIME COLLECTED:

☐ ☐

Medical Medicare PPO Other:_____

4. DIAGNOSIS CODE

Other

The ordering physician or his/her authorized representative must sign his/her name and indicate the date the test is ordered. The signature constitutes a certification that, with respect to tests reimbursed by Medicare or other third party payers, the testing is medically necessary and the results will be used in the management of the patient.

☐Signature on File

Physician/ Representative Signature: _____ Date:_____

5. CLINICAL INFORMATION

Site	Check:	Gross Description	Diagnosis Description
1	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER_____		
2	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER_____		
3	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER_____		
4	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER_____		
5	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER_____		

6. Authorizations

I acknowledge that the laboratory has my permission to release my results directly to the treating physician or facility. I hearby authorize my insureance benefits to be paid directly to the laboratory for services rendered and I agree to endorse any payments received from my insurer and forward them directly to the laboratory for services rendered. By signing this authorization, I allow the release of any medical information necessary to process this claim. I, the undersigned, understand that I am responsible for all co-pays and deductables.

Patient Signature: _____ Date: _____

Name: DOB:

Name: DOB:

Name: DOB:

Name: DOB:

REQUIRED: Attach patient face sheet, as well as front and back copies of current insurance card(s).