THERAPATH
NEUROPATHOLOGY

*REQUIRED FIELDS

Version #: 12-2015

TEST SELECTION FOR SKIN BIOPSY ELECTRON MICROSCOPY (EM) * (Please check all that apply)

- ☐ **CADASIL (Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy)**
- ☐ **Lysosomal and peroxisomal (storage) disorders**
- ☐ **Neuronal ceroid lipofuscinosis (NCL)**
- ☐ **Mucopolysaccharidoses**
- ☐ **Oligosaccharidoses**
- ☐ **Glycogen storage disorders**
- ☐ **Lipidoses**
- ☐ **GM2-gangliosidoses**
- ☐ **Metachromatic leukodystrophy**
- ☐ **Krabbe globoid cell leukodystrophy**
- ☐ **Niemann-Pick's disease**
- ☐ **Inherited neuroaxonal dystrophies**
- ☐ **Adrenoleukodystrophy / adrenoleukomyeloneuropathy**

*COLLECTION DATE:

*COLLECTION TIME: AM ☐ PM ☐

SUBMITTING FACILITY

ONLINE REQUISITION FORM

Please print the submitting Doctor's name and address below.

PATIENT & REFERRING PHYSICIAN INFORMATION*

FIRST NAME:	MI:	LAST NAME:	SUF:
SEX: ☐ M ☐ F	D.O.B.:	SS #:	
ADDRESS:			
CITY/STATE/ZIP:			
PHONE #:		MOBILE #:	
REFERRING MD:		REFERRING PHONE #:	

PATIENT INSURANCE INFORMATION* (Complete below or attach a copy of the insurance card and/or face sheet.)

PRIMARY INSURANCE:		SECONDARY INSURANCE:	
ID/SUBSCRIBER/POLICY #:		ID/SUBSCRIBER/POLICY #:	
GROUP #:	PHONE #:	GROUP #:	PHONE #:
INSURED'S NAME:		INSURED'S NAME:	
EMPLOYER NAME:	PHONE #:	EMPLOYER NAME:	PHONE #:

CLINICAL INFORMATION*

DIAGNOSIS CODES (ICD10 Codes):

CLINICAL HISTORY AND EXAM:

Please indicate the biopsy location(s) below and label the vial(s) with the corresponding site and patient's name.

Vial 1 Body Site: _____

Vial 2 Body Site: _____

Authorization to Release Information and Pay Benefits: I consent to have testing services performed by Therapath on my sample. I hereby authorize and request that my insurer pay any benefits due for these services directly to Therapath. I authorize Therapath to provide my insurer with all of the necessary information, including test results, that is needed to receive payment for these tests I further authorize my insurer to provide Therapath with all pertinent information concerning coverage, payments, appeals and grievances. I agree to submit within 15 days, to Therapath, any payment for these services that were made directly to me. **I authorize Therapath to file any appeal, grievance or claim review to my insurance carrier on my behalf.**

I agree to be personally and fully responsible for any portion of the claim not covered by my insurer and agree to make such payment to Therapath within 30 days of receiving notice. A service charge of 1.5% per month may be charged on balances over 30 days. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default. I further agree and acknowledge that any court action between Therapath, LLC and myself, including, but not limited to, issues relating to payment shall be brought in a court of appropriate jurisdiction in New York County, New York. Therapath, LLC may, at its sole discretion, choose to bring any such action in the jurisdiction in which I reside.

***Patient (or legal guardian) Signature:** _____

THERAPATH USE
CI _____ VR _____ AN _____ AT _____ FE _____