Brigham and Women's Hospital
Founding Member, Mass General Brigham

Mihm Cutaneous Pathology Consultative Service

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PATIENT PATHOLOGY CONSULTATION GUARANTOR FORM

Patient Name:		
DOB:	Sex:	
Address:		
City:	State:	Zip:
Phone:	Fax:	Email:

Billing Information:

Bill Patient's home address as above (patient may be contacted)

Bill Patient's Primary Insurance (patient/insurance may be contacted)

Insurance Company:		Ins. Phone:
Insurance Address:		
Name of Subscriber:		
Date of Birth of Subscriber:	Relationship to Patient:	
Address of Insured:		
City:	State:	Zip:
Policy ID:		
Group #:		Effective Date:
Referring Physician:		
Fax:	Email:	

Bill Contributor

Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	Email:

My signature indicates that I agree to pay all consultation fees and costs associates with completing this consultation. If my insurance is billed, I agree to pay my co-pay, deductible, and/or to provide payment in full if my insurance claim is denied for whatever reason.

Signature of Guarantor: ____

Print Name: ____