AUSTIN NEUROMUSCULAR CENTER

CAP ACCREDITED — COLLEGE of AMERICAN PATHOLOGISTS

CAP#8239200

Clinical Laboratory Improvement Amendments CLIA Certified

CLIA#45D2114599

Pathology Lab Collection Kit Instruction Form

Biopsy Collection Lab Kit Contents
White padded envelope
FedEx Shipping Bag
FedEx Self-Addressed Shipping Label
Biohazard Bag
Zamboni fixative filled microcentrifuge tubes (2)
Microcentrifuge tube labels (2)

Paperwork

- Complete the ANC Pathology Lab Requisition Form in full. (Please note that incorrect or incomplete information will result in processing delays.)
- Include the patient's documentation
  - copy of insurance card (front & back)
  - exams
  - lab results
  - test results

Specimens

- Affix enclosed labels on all specimen tubes. Labels must have all the following information:
  - Patient's name
  - Patient's date of birth
  - Collection site
  - Collection date & time
  - Insert all label specimen tubes into the biohazard bag provided.

Packaging

- Place the ANC Pathology Lab Requisition Form, documentation, and biohazard bag with specimens into the white padded envelope provided.
- Place the white padded envelope in FedEx bag provided.

Shipping

- FedEx, standard overnight delivery, Monday through Thursday. DO NOT ship Friday, Saturday or Sunday. NO WEEKEND DELIVERY.
- Label FedEx label to:
  Austin Neuromuscular Center
  Attn: Pathology Lab
  4705 Spicewood Springs Rd. Ste. 200
  Austin, TX 78759
  P: 512-920-0140 Ext 205
  F: 512-920-0142
  lab@austinneuromuscle.com

Skin Biopsy Pathology Fees

CPT	Units	Ins Fee	Ins Total	Self-Pay Fee – 30% discount*	Self-Pay Total*
88305	2	$234.45/unit	$468.90 – 2 units	$164.11/unit – (-$70.34)	$328.22
88314	2	$332.79/unit	$665.58 – 2 units	$232.95/unit – (-$99.84)	$465.90
88356	2	$799.38/unit	$1,598.76 – 2 units	$559.56/unit – (-$239.82)	$1,119.12
88342	2	$347.67/unit	$695.34 – 2 units	$243.37/unit – (-$104.30)	$486.74
88341	2	$307.65/unit	$615.30 – 2 units	$215.36/unit – (-$92.29)	$430.72
			$4,043.88 – Total		**$2,830.70 - Total**

Self-pay patients are required to pay in full. To initiate a payment plan, a 50% payment of $1415.35 must be paid upfront, credit card agreement must be authorized, and recurring payments must be set up in Athena for the remaining balance. Self-pay patients may set up 2 to a maximum of 4 recurring payments to pay off the remaining balance of $1415.35.

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Pathology Lab Requisition Form

Patient, Ordering Physician & Facility Information			
Patient Name		Ordering Physician/NPI#	
Date of Birth		Facility Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Phone	☐ Home ☐ Cell	Room/Suite	
Gender	☐ Female ☐ Male	Phone	Fax

Patient Insurance Information (Complete all information AND send with copy of insurance card(s)-front and back)	
Primary Insurance	Secondary Insurance
ID/Subscriber/Policy #	ID/Subscriber/Policy #
Group #	Group #
Insured's Name	Insured's Name
Insured's Date of Birth	Insured's Date of Birth
Relationship To Patient	Relationship To Patient

Clinical Information (Complete AND attach copy of records, clinical history, exams, lab and test results)	
☐ Diagnosis Codes (ICD 10)	☐ Attach clinical records, history exams, labs and test results

Requested Test	
☐ **SKIN BIOPSY/SMALL FIBER NEUROPATHY EVAL ROUTINE PANEL** *Frozen Sections: H&E, PGP 9.5, Congo Red, CD3*	☐ **IMMUNE MYOPATHY / NEUROPATHY ROUTINE PANEL** *MHC Class I, C5b-9 (MAC), CD3*
☐ **SKELETAL MUSCLE BIOPSY ROUTINE PANEL** *H&E x 2, NADH, GT, ATPase pH 9.4, 4.6 and 4.3, Congo Red, Sudan Black, Alkaline Phosphatase, Esterase, Periodic Acid Schiff (PAS), Cytochrome Oxidase, Succinic Dehydrogenase, Phosphorylase AMPDA, Morphometry*	☐ **DYSTROPHY ROUTINE PANEL** **Immunohistochemistry (IHC) or Western blot (WB) performed at WashU Neuromuscular Lab** Dystrophin (4 epitopes); Sarcoglycans (α, β, γ, δ); Desmin; Emerin; Caveolin-3; Laminin-a2; a-Dystroglycan; Dysferlin; Phalloidin; LAMP2
☐ **PERIPHERAL NERVE BIOPSY ROUTINE PANEL** *Frozen Sections: H&E, GT, Congo Red, Alkaline Phosphatase, Esterase, and teased nerve*	☐ **BIOCHEMISTRY** EXTRA SPECIMEN MAY BE REQUIRED (> 0.5 cm^3, 100 mg); performed at W Neuromuscular Lab ☐ Mitochondrial Oxidative Enzymes ☐ Glycogen Pathways

Biopsy Location			
Skin	A (Ankle) 10cm proximal to the lateral malleolus (calf)	☐ Right	☐ Left
	T (Thigh) 10cm proximal to the lateral patella (thigh)	☐ Right	☐ Left
Muscle	Site:	☐ Right	☐ Left
Nerve	Site:	☐ Right	☐ Left

Specimen Collection			
Date:	Time:	☐ AM	☐ PM

Instructions Checklist (Make sure you follow all instructions)
☐ Affix enclosed labels on vials with the patient's name, date of birth, collection site, date, and time.
☐ Insert labeled vials in the biohazard bag.
☐ Place this Requisition Form along w/copy of insurance card(s) (front & back), records, clinicals, exams, lab, test results, and specimens in the white envelope.
☐ Ship via FedEx for Monday-Thursday same-day pickup ONLY with standard overnight delivery. NO WEEKEND DELIVERY ACCEPTED.

Consent to Test & Authorization to Release Information and Payment

I give my consent for Austin Neuromuscular Center (ANC) to perform testing services on my sample. I authorize and request my insurer to directly pay any benefits owed for these services to ANC. ANC is allowed to provide my insurer with all the necessary information, including test results, to receive payment for these tests. I give permission for my insurer to provide ANC with any relevant information concerning coverage, payments, appeals, and grievances. I agree to pay ANC directly within 15 days for any services that were paid to me. ANC is authorized to file any appeal, grievance, or claim review with my insurance carrier on my behalf. I am personally responsible for any portion of the claim not covered by my insurer and must make the payment to ANC within 30 days of receiving notice. A service charge of 1.5% per month may apply to balances over 30 days. If I do not pay my account on time, I am responsible for collection fees and interest, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I am responsible for collection fees and interest. I acknowledge that any court action between ANC and myself shall be brought in a court of appropriate jurisdiction in Travis County, Texas, at ANC's sole discretion. However, ANC may choose to bring any such action in the jurisdiction where I reside.

Signature of Patient or Authorized Representative	Date: