General Pathology

True Partners in Laboratory Diagnostics

Alliance Laboratories Southeast
7200 W. Camino Real, suite 330
Boca Raton, FL 33433
Tel: 561-453-1234 Fax: 561-453-1238
ClientSupport@AllianceLab.com

PATIENT INFORMATION

Last Name	First Name		
Address		Apt #	
City	State	Zip Code	
Phone	Sex	Age	DOB
Social Security #	Medical Record #		

COLLECTION INFORMATION

Collection

Date: ____/____/____

Time: ____:____ am/pm

LAB USE ONLY

Case #: _____

Date Received: ____/____/____

Time Received: _____

BILLING INFORMATION

Name of Insured		
Company Name		
Street Address		
City	State	DOB
Policy #	Group #	
Medicare/ Medicaid #	Referral #	

ACCOUNT INFORMATION

CLINICAL INFORMATION / DIAGNOSIS

ICD-10 CODE: _____ _____

_____

HISTOLOGY

Specimen(s) Description:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

CYTOLOGY

Specimen: Urine
Test(s) required. Please check box.

☐Cytology + Bladder Ca by FISH (VesicDX) + Chlamydia/Gonorrhea

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☐Cytology + Chlamydia/Gonorrhea

☐Cytology

☐Bladder Ca by FISH (VesicDX)

☐Chlamydia/Gonorrhea

Other: _____

_____

_____

Specimen(s) Description:

1. _____
2. _____
3. _____
4. _____

Pt. Name: _____	Pt. Name: _____	Pt. Name: _____	Pt. Name: _____	Pt. Name: _____	Pt. Name: _____

Non-Medicare Patients: I hereby authorize Alliance Laboratories to furnish my designated insurance carrier with the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Alliance Laboratories. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____