MediPath
PATHOLOGY SERVICES

TopLine MD Alliance

DATE: _____

PATIENT'S NAME: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

E-MAIL: _____

I HAVE BEEN AWARE THAT DR._____ WILL NOT BE COLLECTING PAYMENT IN THE OFFICE FOR ANY LAB TEST(S) RENDERED TO ME. THE AMOUNT ($) THAT I AM PAYING TODAY IS STRICKLY FOR SERVICES RENDERED BY THE PHYSICIAN.

I UNDERSTAND THAT I MAY RECEIVE A SEPARATE BILL FROM THE LABORATORY FOR THEIR SERVICES IF NOT COVERED BY MY INSURANCE CARRIER AND AGREE TO PAY THE COSTS INCURRED.

SIGNATURE: _____

Medipath, LLC
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