PAPS
Preferred Anatomic Pathology Services

UNINSURED/SELF-PAY PATIENT PRE-PAYMENT FORM

Patient Name: _____

Date of Birth: _____ Date of Service: _____

PRE-PAY AGREEMENT

Your physician has ordered the processing of a pathology specimen(s). Below are the charges indicated by test that will be charged for **uninsured, self-pay patients**. Depending on the type of biopsy or need for special stains as determined by a pathologist, additional charges may be applied.

Credit Card Information

TYPE OF CARD (Circle One): VISA MASTERCARD

CREDIT CARD #: _____

Name as it appears on card: _____

Security Code: _____ Expiration Date: _____

Billing Address: _____

*** To deliver Credit Card information by phone, please contact Dawn or Jamie at (337) 706-1601.**

Your signature on this form authorizes **Preferred Anatomic Pathology Services, LLC** to charge your credit card for the pathology services rendered. Once your card has been charged, a statement will be mailed to you for your records. If your card is declined, you will receive a call and/or statement requesting corrected information. ***If no response within 30 days, pricing will revert to 100% of PAPS Pathology standard charge.***

_____ _____

Cardholder Signature Date

GYN/MOLECULAR:		TISSUE:	
Thin Prep Imaged Pap	$50	Biopsy	$90
CT (Chlamydia)	$55	Cervix/Cone/LEEP	$90
NG (Gonorrhea)	$55	IHC Stains	$85
HPV (Human Papillomavirus)	$55		
BD Max or Thin Prep Vaginal Panel (BV, Candida & Trich)	$150		
GBS	$55		

FOR OFFICE STAFF: Please seal the completed form in a PAPS envelope and send along with the specimen and requisition. The patient's credit card will be charged once pathology has been completed.

CONFIDENTIAL