The Breast Cancer Consultation Service
Michael D. Lagios, M.D.

CONTRACT FOR SERVICES

Description: The Breast Cancer Consultation Service is designed to provide self-referred patients like yourself with the opportunity to have an independent comprehensive review (second opinion) of their diagnostic materials, including biopsy slides, other special studies, and mammograms, prior to the initiation of treatment. The Service will formally review these materials and prepare a written report, which will include recommendations. The results of the review will be discussed with you and your support people in a separate session by conference call or in person. Both you and all of your designated physicians will be provided copies of the report. Our goal is to provide you with information so that you can confidently make the best decision regarding your treatment. The Service is interactive and your preferences are always taken into consideration in making treatment recommendations.

Fees: The services provided may not be covered by insurers. You will be responsible for all charges incurred. A summary bill will be provided to submit for your insurer, but the Service cannot bill for you. **Payment may be made by credit card or check at the time of the Service, but a valid credit card number is required for registration**. The credit card or check will not be processed until the service is completed.

Review:	Includes review of pathology slides, special studies (estrogen and progesterone receptor and oncogene analysis), DNA ploidy determination, and mammograms when pertinent. Results provided in a formal, written pathology report	$425.00
Consultation:	A comprehensive discussion with patient and support people. The in-person consultation is tape recorded for your convenience. We suggest you tape the teleconference	$210.00
	Total:	**$635.00**

Financial Responsibility (Please read and sign): I understand that I am fully responsible for payment of all Breast Cancer Consultation Service fees and that the Service cannot bill my insurance company.

_____ _____
Signature Date

❒ I wish to pay by credit card: ❒ Visa ❒ MasterCard ❒ Discover ❒ American Express

❒ I wish to pay by check **(a credit card # is still required).**

Credit Card Number: _____ Exp. Date: __ __ – __ __

Security code: _____

Patient Information:

Name: _____ Birth Date: _____

Address: _____
Street City State Zip

Phone #'s: Home: _____ Work: _____ Cell: _____

Fax: _____ Email: _____

Physician(s) of Record to Receive Report (optional): _____

Physician Phone: _____ Fax: _____

Please complete forms using BLACK ink.

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