Division of Autopsy Services
Department of Clinical Laboratories
The Ohio State University Wexner Medical Center

Agreement of Financial Responsibility (AUT-40)

Patient Name: _____ **Date of Birth:** _____

Financial Responsibility for this autopsy is assumed by (select one) ("Responsible Party"):

☐ Facility with a Contract or Letter of Instruction from OSUWMC Autopsy Services
(Facility will receive an invoice following completion of the procedure)
(A representative MUST sign below for financial accountability in order to proceed with autopsy request)

☐ Private Individual
(ALL payment information will be retrieved via telephone by OSUWMC staff)
(FULL PAYMENT DUE PRIOR TO START OF AUTOPSY)

I, as the Responsible Party, hereby authorize the performance of the following basic services with the associated fees (select all applicable):

BASE AUTOPSY RATES

☐ Complete Examination: $_____
☐ Limited Examination, Excluding: $_____
List exclusions: _____
☐ Limited Examination, Including: $_____
List inclusions: _____
☐ Limited Examination, Chest-Only: $_____
☐ Limited Examination, Abdomen & Pelvis-Only: $_____
☐ Brain-Only (includes dementia work-up): $_____
☐ Research Procurement (Brain or single-cavity): $_____
☐ Research Procurement (Brain/SC or two cavities): $_____

ADDITIONAL FEES

☐ Mesothelioma Work-up (in addition to base autopsy fee): $_____
☐ Asbestosis Work-up (in addition to base autopsy fee): $_____
☐ Dementia Work-up (in addition to base fee, EXCEPT BRAIN ONLY): $_____
☐ Transportation Fee (if applicable): $_____
☐ Other (specify): $_____
☐ Other (specify): $_____

TOTAL CHARGES: $_____

For base autopsy rates, please refer to the OSUWMC Regional Autopsy Center website. In the event that the autopsy is complicated by unanticipated findings, additional tests (with additional charges assigned to the Responsible Party) may be required to finalize and/or confirm a diagnosis. The OSUWMC Regional Autopsy Center will make 3 attempts to notify the Responsible Party of additional charges and to seek authorization to proceed with testing beyond basic services. If the Responsible Party cannot be contacted or declines the additional testing/charges, only a general diagnosis based on basic light microscopy will be provided.

I, as the Responsible Party, agree to pay the Total Charges as illustrated above, by the following method:

☐ Invoice Sent to Facility (Upon Completion of Final Report)

☐ Private Payment (Select Payment Type Below)

☐ Check or Money Order (Must be Sent with the Patient When Transported to OSUWMC)
Checks made payable to: OSU Department of Pathology

☐ Credit Card[1]

Printed Name: _____

Signature: _____

Facility Name (if applicable): _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Billing Address: _____
Building / Street Address

_____
City/State/Zip

AFFIX PAYMENT PROCESSING LABEL

[1] Credit card information will be acquired via telephone with Division of Autopsy Services staff prior to initiation of the autopsy.