ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that your insurance will not pay for the item(s) or service(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when Insurance rules are met. The fact that Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor or therapist recommends it. Right now, in your case, **Your Insurance probably will not pay for -**

Items or Services:

Consultation*.
Adjustments and/or any treatments for maintenance care*.
Spinal Decompression*, Cold Laser Therapy*.
Custom Fit Orthotics*, Nutritional Support*.

* *Will be verified for consideration, but reimbursement not expected.*

Because:

Non-covered services.

The purpose of this form is to help you make an informed choice about whether of not you want to receive these items or services, knowing that you might have to pay for them yourself.
Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you do not understand why your Insurance probably will not pay.
- We have explained and provided you with a copy of your total expense with care in this office. If you have any questions, ask us and we will be happy to explain your benefits to you in detail.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that my Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my Insurance. I understand that you may bill me for items or services and that I may have to pay the bill while Insurance is making its decision. If Insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to my Insurance and that I will not be able to appeal your opinion that Insurance will not pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your Insurance, your health information on this form may be shared with your Insurance. Your health information which your Insurance sees will be kept confidential.

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