

Patient's Name: \_\_\_\_\_ Insurance or Medicare # \_\_\_\_\_

## Advance Beneficiary Notice (ABN)

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

We expect that your insurance carrier or Medicare will not pay for the item(s) or service(s) that are described below. Your insurance or Medicare does not pay for all of your health care costs. Insurance carriers and Medicare only pay for covered items and services when their rules are met. The fact that your insurance carrier or Medicare may not pay for a particular item or services does not mean that you should not receive it. There may be a good reason your doctor recommended it.

### Items or Services:

- |   |  |                                     |   |   |
|---|--|-------------------------------------|---|---|
| <input type="checkbox"/> HGB A1C or Glucose         | <input type="checkbox"/> Biopsy            | <input type="checkbox"/> EKG        | <input type="checkbox"/> Skin tag removal     | <input type="checkbox"/> Tendon/trigger Injection |
| <input type="checkbox"/> Lipid panel or Cholesterol | <input type="checkbox"/> Cryosurgery       | <input type="checkbox"/> Spirometry | <input type="checkbox"/> Paring of wart       | <input type="checkbox"/> Bursa Injection          |
| <input type="checkbox"/> AST/AST or PT/INR          | <input type="checkbox"/> Excision          | <input type="checkbox"/> Nebulizer  | <input type="checkbox"/> Insert pessory/other | <input type="checkbox"/> Aspiration/inj ganglion  |
| <input type="checkbox"/> Urinalysis or Strep        | <input type="checkbox"/> Shave lesion      | <input type="checkbox"/> Anosocopy  | <input type="checkbox"/> Foreign body removal | <input type="checkbox"/> Other                    |
| <input type="checkbox"/> Medication/vaccines        | <input type="checkbox"/> Preventative Exam |                                     |   |   |

### Because:

- Your insurance carrier or Medicare may not pay for this item or service for your condition
- Your insurance carrier or Medicare may not pay for this item or service due to frequency limits
- Your insurance carrier or Medicare usually does not pay for this service

The purpose of this form is to help you make an informed choice about whether or 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 don't understand why your insurance or Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost:** \_\_\_\_\_), in case you have to pay for them yourself or through other insurance.

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 carrier or Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance carrier or Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance carrier or Medicare is making its decision. If my insurance or Medicare does pay, you will refund to me any payments I made to you that are due to me. If my insurance or Medicare 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 carrier's or Medicare'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 carrier or Medicare and that I will not be able to appeal your opinion that my insurance carrier or Medicare won't 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 carrier or Medicare, your health information on this form may be shared with your insurance or Medicare and it will be kept confidential by them.