A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-covered/ Non-approved (ABN)

NOTE: If your insurance doesn't pay for the services listed in **D** below, you may have to pay. YOUR INSURANCE does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect YOUR INSURANCE may not pay for the services in **D** below.

D.	E. Reason YOUR INSURANCE May Not Pay:	F. Estimated Cost
New Patient of Established patient exam not separately reimbursable with an office visit	**Spending caps/Insurance no longer pays an adequate amount to cover both an adjustment and exam on the same day**	**100.00**
Pre-Authorization/ Medical necessity required	**Pre-Authorization is not obtained/ Services deemed not medically necessary**	**60.00**
Spinal manipulation or office visit	**Medical necessity. Over visit or monitary limits.**	**60.00**
Any therapy performed	**Medical necessity.**	**Up to 60.00/visit total**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but YOUR INSURANCE cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want YOUR INSURANCE billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if YOUR INSURANCE doesn't pay, I am responsible for payment, but **I can appeal to YOUR INSURANCE** by following the directions on the EOB**.** If YOUR INSURANCE does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the services listed above, but do not bill YOUR INSURANCE. You may ask to be paid now as I am responsible for payment. **I cannot appeal if YOUR INSURANCE is not billed**.

☐ **OPTION 3.** I don't want the services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if YOUR INSURANCE would pay.**

H. Additional Information: Managed care will reduce the cost of your care, but it is the doctor whom decides the quality of your care. Should you choose Option 3 we will have to refer you to a primary care doctor for other options.

This notice gives our opinion, not an official YOUR INSURANCE decision. If you have other questions on this notice or YOUR INSURANCE billing, call **1-800-924-7141.**

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: