Advance Beneficiary Notice (ABN)

HIPAA
Protected Health Information
Authorized Access Only

CONFIDENTIAL

Patient Name ______________________________ Social Security # ______________

NOTE: Dear Patient, You need to make an informed choice about receiving Primary Chiropractic Health Care, other clinical services, rehabilitation, nutrition, and/or other health care items or services.

This office expects that Medicare will not pay for the clinical items and/or services/supplies that are described below and on next sheet. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met (Medicare makes this arbitrary determination, not your Doctor). The fact that Medicare may not pay for a particular procedure, item or service does not mean that clinically you should **not** receive it. There may be good reasons that your Doctor of Chiropractic has recommended it. Right now, in your case, Medicare probably will not pay for –

Items or Services:
Chiropractic Care after 12 visits; Exams–X-rays–Traction–Nutrition–Supports–Pillows; etc. (See waiver form)

Because:
Medicare usually does not approve ongoing care, supportive care, and/or maintenance care that goes beyond 12 visits.
Note: We have no actual definition of "Maintenance Care" from Medicare.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these Primary Chiropractic services/supplies and/or items, 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. Then choose one option before you sign below.

- Ask us to explain, if you don't understand why Medicare probably won't pay for your care past 12 visits.
- Ask us how much these special supplies, 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/Chiropractic care.
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items and services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you for the particular items or services. If 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 that will cover these items or services.

I understand that I can appeal 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 Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

______________ ______________________________
Date Signature of patient or person acting on patient's behalf

______________ ______________________________
Date Witness Signature Staff / Notary

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 Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Similar to OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2001)

Please read the back of this form, sign and date.

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