

Scottsdale Family Health

Patients Name: _____ DOB: _____ Date: _____

ADVANCE BENEFICIARY NOTICE (ABN)

We expect that Medicare/your insurance may not/will not pay for the medical services that are described below. Certain insurances do not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that you're insurance may not pay for a particular item or service does not mean you should not receive it. There may be a good reason your doctor recommended it. The purpose of this form is to help you make an informed choice whether or not you want to receive the services your doctor is recommending. Before you make your decision about your options, you should **read this notice carefully**.

Ask us to explain, if you do not understand why Medicare/other insurances probably will not pay.

Ask us how much these services may cost you in case you have to pay for them yourself or through other insurance. We will provide you with an **estimated** cost.

*Below are some services that your insurance may not cover: **These are just Examples:***

Office Procedures:	Immunizations/Injections	Laboratory	
Cyst Removals	Hepatitis A ANA	BMP	PSA
Skin Tag removals	Allergy PPD	PT/INR	PTT
Toe Nail removals	Injection B-12	CBC	TSH
Anoscopy	Hepatitis B Depo-Provera	GC/Chlamydia	ANA
EKG	HIB Toradol	CMP	CRP
Ear Irrigation	IPV Synvisc/Hylan	Culture, Throat	UA
Rapid Strep	MMR Marcaine	T4, Free	Lipase
Coagucheck	Influenza Rocephin	T4, Total	
Urine Dip	Yellow Fever Varivax	T3, Free	
Liquid Nitrogen	Typhoid	T3, Total	
Pap Smear	Pneumovax	Pregnancy Tests	
SVN Treatment	Meningococcal	Lipid Panel	
		HIV Screen	
		Hepatitis Panel	

Other Office Procedures, Immunizations/injections, Laboratory services that are not listed are still your responsibility if your insurance does not pay.

Please choose ONE option.

Check One Box.

Sign and Date your Choice.

Option 1. (YES) I want to receive the services recommended by my physician. I understand that my insurance will not decide whether to pay unless I receive these services. Please submit my claim to my insurance. I understand that you may bill me for services and that I am responsible for the bill, if my 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 other insurance that I have. I understand I can appeal my insurance decision.

Option 2. (NO) I have decided not to receive the services recommended by my physician. I will not receive these 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 my insurance may not pay. I will notify my doctor who recommended these services that I do not want them.

Date: _____ Signature: _____

This ABN is active today and all future dates of services provided to you by Scottsdale Family Health.