SPECIALTY
SURGICAL CENTER

ADVANCE BENEFICIARY NOTICE (ABN)

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

We expect that your insurance provider will not pay for the item(s) or service(s) that are described below. Your insurance provider does not pay for all of your health care costs. Your insurance provider only pays for covered items and services when specific criteria are met. The fact that your insurance provider 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 recommended it. Right now, in your case, your insurance provider may not pay for:

Items or Services:
Because:

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. Because 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 provider may not 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 AND DATE** YOUR CHOICE.

☐ **OPTION 1. YES. I want to receive these Items or Services.**

I understand that my insurance provider will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance provider. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance provider is making its decision. If my insurance provider does pay, you will refund to me any payments I made to you that are due to me. If my insurance provider 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 provider'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 provider and that I will not be able to appeal your opinion that my insurance provider will not pay.

____________________________________ ____________________

SIGNATURE OF PATIENT OR PERSON ACTING ON PATIENT'S BEHALF **DATE**

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 provider, your health information on this form may be shared with the provider. Your health information which your insurance provider sees will be kept confidential by your insurance provider as well.

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Patient Label Here

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