F E R N L E Y   C H I R O P R A C T I C
DAVID KAHN D.C.

Advance Beneficiary Notice (ABN)

YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THESE HEALTHCARE ITEMS OR SERVICES
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 your insurance may deny these services and you will be financially responsible for the full balance of your visits. *Before you make a decision about your options, you should read this entire notice carefully.*

- ASK us to explain if you do not understand why your insurance may not pay.
- ASK us how much these items or services will cost you in case you have to pay for them yourself.

Your insurance company may not pay for the following reasons:

- May have a set visit maximum;
- May not cover services or equipment for the reported condition;
- May not pay for like services by more than one doctor during the same time period or specialty;
- May have a set maximum for modalities in one visit.

Please choose one of the following options by initialing on the line provided.

☐ Option 1. **YES! I want to receive these items or services and have this office bill my insurance.**
I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim. I understand that you may bill me for the items or services and that I may have to pay the bill while my insurance is making a decision. If my insurance does pay, you will refund to me any payments that I have made that are due to me. If my insurance denies payment, I agree to be personally responsible for the full amount of charges. I will pay personally, out of pocket or through another insurance.

☐ Option 2. **YES! I want to receive these items or services without using my insurance.**
I understand that Fernley Chiropractic will not bill my insurance, but that I can individually bill my insurance company.

☐ Option 3. **YES! I want to receive these items or services without using my insurance.**
I understand that Fernley Chiropractic will not bill my insurance and I cannot bill my insurance company individually. This agreement will waive any and all contracts and rates through my insurance company.

☐ Option 4. **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 and that I will not be able to appeal your opinion that my insurance will not pay.

Print and sign name of patient or responsible party   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 office. We may, however, have to share this information with your insurance provider if they request it.

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