

Patient Name:

Chart #:

ADVANCE BENEFICIARY NOTICE (ABN)

As a consumer you need to make a choice about receiving certain health care items and services. Your insurance company does not pay all of your health care costs and only pays for covered services when an insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. Your doctor has recommended the items or services listed below. Your insurance company, _____, may not pay for the listed items or services.

Items/Services: Powered Rotational Phlebectomy (Trivex)

The purpose of this form is to help you make an informed choice about whether or not you wish to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why your insurance company may not pay
- Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance.
- A deposit of \$1000 must be made prior to the procedure.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE THIS FORM

YES, I want to receive these items or services.

I understand that my insurance company may not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items and services and that I may have to pay the bill while my insurance company is making its decision. If my insurance company does pay, you will refund to me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment within 90 days of the procedure. I understand I can appeal my insurance company's decision, but I am still responsible for the bill pending results of any appeal.

(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 company and that I will not be able to appeal your opinion that my insurance company won't pay.

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

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