Center for Pain and Spine Care

Authorization of Record Release

Patient Name: _____

DOB:_____

_____ , authorize the release of all medical records to Dr. Terrance Winn at the address below.

I understand that "all" medical information includes all of my medical information, including reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B and C testing/treatment and/or sensitive information.

If at any time you wish to revoke this authorization, please request so in writing.

Thank you.

Patient's Signature: _____ **Date:** _____

I will no longer continue treating at the Center for Pain and Spine Care with Dr. Terrance Winn. Please forward ALL my medical information, including reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B and C, and testing/treatment to the following doctor/office:

DOCTOR/OFFICE NAME: _____

ADDRESS: _____

_____

PHONE NUMBER: _____ FAX NUMBER: _____

Patient's Signature: _____ Date: _____

Patient Bill of Rights

As a patient at Center for Pain and Spine Care, a New Jersey healthcare facility, you have the following rights under state law and regulations.

1. **To be informed** of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights. Also given a written and verbal explanation of these rights, in terms the patient could understand. Center for Pain and Spine Care shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility.

2. **To be informed** of services available in the facility, of the names and Professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate.

3. **To be informed** if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions and to refuse to allow their participation in the patient's treatment.

4. **To receive** from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health; or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record.

5. **To be given** an informed, written consent prior to the start of specified, non-emergency medical procedures or treatments. Your physician should explain to you-in words you understand-specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives.

6. **To refuse** medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life-threatening or the procedure is required by law. Such refusal shall be documented in the patient's medical record.

7. **To expect** and receive appropriate assessment, management and treatment of pain and reasonable continuity of care.

8. **To be included** in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, role and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices.

9. **To a copy of your medical record,** at a reasonable fee, within 30 days after a written request to Center for Pain and Spine Care.

10. **To be advised in writing of** Center for Pain and Spine Care's rules regarding the conduct of patients, family members and visitors.

11. **To be free from mental** and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to, protect the patient or others. Drugs and other medication shall not be used for discipline of patients or for convenience of facility personnel.

12. **To confidential treatment of** information about the patient Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health facility to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

13. **To be treated** with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are

discussing the patient. Also to have physical privacy during medical treatment and personal hygiene functions, unless you need assistance.**To not be required** to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, state, and federal laws and rules.

14. **To exercise civil** and religious liberties, including the right to independent personal decisions. No religious beliefs, or practices or any attendance at religious services, shall be imposed upon any patient.

15. **To not be discriminated** against because of race, age, religion, sex, national origin, sexual preferences, handicap, diagnosis, ability to pay, source of payment or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility:

16. **To present questions or grievances** to CPSC at (732) 360-1800 and receive a response in a reasonable time. Center for Pain & Spine Care must provide you or your guardian with the names, addresses, and telephone numbers of the government agencies to which you can make a complaint and ask questions. Such as the New Jersey Department of Health & Senior Services. You may call the complaint hotline at (800) 792-9770.

Below is the patient and family responsibility as a patient at Center for Pain and Spine Care:

1. To provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations and other issues related to his/her health.
2. To make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
3. To follow the treatment plan established by the provider, including the instructions of health professionals as they carry out the physician's order.
4. To keep appointments and/or notify the clinic when he/she is unable to do so.
5. To assure that the financial obligations of his/her medical care are fulfilled as promptly as possible.
6. To follow Center for Pain and Spine Care's policies and procedures.
7. To be considerate of the rights of other patients and personnel.

This Patient Bill of Rights is an abbreviated summary of the current New Jersey law and regulations governing the rights of Center for Pain and Spine Care patients. For more complete information, consult the NJ Department of Health regulations at www.state.ni.us/health regarding NJAC 8:43 G-4, or Public Law 1989 Chapter 170.

Advance Directives

You have the right to enter into an advance directive. An advance directive means a written statement of your instructions and directions for health care in the event of your future decision making incapacity. An advance directive may include a proxy directive or an instruction directive, or both (N.J.A.C. 8:43 A-l-3). Center for Pain and Spine Care does not honor advance directives. However, you may provide Center for Pain and Spine Care a copy of your advance directive in the event that you require additional treatment at another health care facility. Center for Pain and Spine Care will ensure your advance directive is forwarded to that facility.

Out of Network Disclosure

Please take notice that Center for Pain and Spine Care is non-participating or contracted with any insurance provider EXCEPT Medicare, Blue Cross/Blue Shield, Cigna & UHC/Oxford. As such, part or all of your upcoming procedure may be considered "out-of-network". You may be personally responsible for the co-payment, co-insurance, deductible, or other charges associated with such "out-of-network" services that are not covered by your insurance carrier.

Physician Ownership

I have been informed that physician has financial interest in Center for Pain and Spine Care and Union Surgery Center.

I/We sign this with the knowledge and understanding that the rights of the patient can only benefit the patient's interest individually and further, that these rights have been explained to me/us verbally. By signing you or your legal representative, acknowledge that: (1) you have been informed that part or all of your procedure will be considered "out-of-network", if applicable; (2) you have the right to enter into an advance directive; (3) Physician Ownership.

Patient Signature _____ **Date:** _____
(Parent or Legal Guardian)

Revised: 5/2012

Center for Pain and Spine Care

Please complete the following and check all that apply:

HIPAA DISCLOSURE AND AUTHORIZATION

I hereby acknowledge that I have been given opportunity to request materials of the Health Information Portability and Accountability Act (HIPAA)/Notice of Privacy Practice.

I have received a copy of Center for Pain and Spine Care's Notice of Privacy Practices.
I authorize my physician/physician's staff to disclose my protected health information to:

- ☐ Myself ONLY
- ☐ My Spouse/Partner (Name: _____)
- ☐ Parent (Name: _____)
- ☐ Other (Name: _____)

I give my permission to release any information from my visit to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I wish to have the following restrictions to the disclosure of my health information:

_____

_____

Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues.

Indicate your choice:

- ☐ YES, I give permission for medical information to be left on my voicemail.
- ☐ NO, I do NOT want medical information left on my voicemail.

Please Print Name: _____ **Date of Birth:**_____

Patient Signature: _____ **Date:**_____

Parent or Legal Guardian:_____

Parent or Legal Guardian Signature: _____

*We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, Patient Rights and Physician Ownership, but was not able to because: ☐ Individual Refused to Sign ☐ Emergency Situation prevented us from doing so.

Center for Pain and Spine Care

STATEMENT OF FINANCIAL RESPONSIBILITY

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to Center for Pain and Spine Care (the "CPSC") of any insurance benefits otherwise payable to me or on my behalf for the services performed by CPSC staff, its affiliates and subsidiaries. This Assignment of Benefits is valid for all insurance companies and programs, including Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize CPSC, it affiliates and subsidiaries to release medical information related to the procedure(s) as may be requested by third party payers in order to process payment of my claims.

CHARGES

I understand that the fees for anesthesia services are separate from the Surgery Center's facility fees and my surgeon's fees. I understand that CPSC is only a network provider with Medicare, and Blue Cross/Blue Shields. The payment by your insurance company may be based on your out-of-network benefits and the status of your deductible.

APPEAL, DOBI AND ARBITRATION

I consent to and authorize CPSC to file any appeal for payment, mediation by DOBI and arbitration by an attorney on my behalf.

CREDIT POLICY

After your procedure, a claim will be filed with your insurance carrier. You will be notified when an action by your insurance company has been taken. At all times, you are fully responsible for any and all deductible, co-pays and co-insurance. Your insurance contract is between you and the insurance company. It is your responsibility to question your insurance company about delays in payment, amount of payment and/or denial of coverage, as well as any requirements to have a second surgical opinion and pre-certifications If any funds are owed, payment will be expected within 10 days of the receipt of the notice.

If your insurance company issues payment to you, you are responsible to send CPSC the full payment along with a copy of the Explanation of Benefits that came with your insurance company check. In the event that you do not forward your insurance payment in timely manner and we are forced to utilize the services of a collection agency and/or an attorney, you will be responsible for all of the costs of collection *in* addition to the amount originally owed by you.

I HAVE READ AND UNDERSTAND THE TERMS OF THIS FINANCIAL RESPONSIBILITY STATEMENT

Patient's Signature _____ **Date** _____

(Parent/Guardian if minor/dependent)

Center for Pain and Spine Care

NARCOTIC CONTRACT

I, _____, understand that in order to continue to receive medical care for the treatment of pain from Dr. Terrance Winn, I must comply with the following rules.

1. I will take the medication at the dose and frequency prescribed. Any changes in the dose and/or frequency will be discussed with Dr. Winn beforehand.
2. I will receive prescriptions monthly.
3. I will comply with my scheduled appointment. I understand that my prescriptions will **ONLY** be refilled at the scheduled appointment.
4. I will not receive controlled substances or any other pain medication from any physician other than Dr. Winn.
5. I will tell my primary care physician that I am have a narcotic contract with Dr. Winn.
6. I will consent to random drug testing.
7. I will protect my prescribed medication. I will **NOT** expect Dr. Winn to provide replacement medication in the event that the medication is lost, stolen or damaged. I will report stolen medication to the police. After Dr. Winn's office confirms the police report of the stolen medication, Dr. Winn will then determine whether or not the medication will be replaced.
8. In the event of an emergency room visit, I am required to inform Dr. Winn within 24 hours.
9. I will not take any illegal substances, such as Cocaine, Heroin, or any other illegal drugs.
10. I will not share, sell, or trade my medication with anyone.

THIS CONTRACT WILL BE PLACED IN MY MEDICAL CHART.

_____ _____

Patient Signature Date

A. Notifier: Center for Pain and Spine Care

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for services provided, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive services.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want to receive services. You may be asked to pay now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want to receive services, but do not bill Medicare. You may be asked to pay now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want to receive any services. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Center for Pain and Spine Care

NOTICE OF PRIVACY PRACTICE

Effective Date: 4/14/03

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AM) DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR 'HEALTH INFORMATION IS IMPORTANT TO US.

If you have any questions about this notice, please contact the Privacy Officer, CPSC, 3 Hospital Plaza, Suite 313, Old Bridge, NJ 08857.

WHO WILL FOLLOW THIS NOTICE:

This Notice describes CENTER FOR PAIN AND SPINE CARE and that of:

- Any health care professionals authorized to enter information into your medical chart.
- All departments and units of Pain Medicine Physicians.
- My member of a volunteer group we allow to help you while you are in Pain Medicine Physicians.
- All employees, staff and other Pain Medicine Physicians personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at CENTER FOR PAIN AND SPINE CARE. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by CENTER FOR PAIN AND SPINE CARE, whether made by CENTER FOR PAIN AND SPINE CARE personnel or your personal doctor. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifieds you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you, and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosure we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use and disclose your protected health information (PHI) to provide, coordinate, or manage your medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Center for Pain and Spine Care personnel who are involved in taking care of you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. This includes the management or coordination of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Also your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

For Payment. We will use and disclose medical information about you so that the treatment and services you receive or may receive at Center for Pain and Spine Care maybe billed to an insurance company, third party or you. For example, obtaining approval for a hospital stay may require that your relevant protected health information (PHI) be disclosed to the heath plan to obtain approval for the hospital admission.

For Health Care Operations. We may use and disclose, as needed, your protected health information (PHI) in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of Medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the front desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Appointment Reminders. We may use and disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about your for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients needs for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave Center for Pain and Spine Care. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care at Pain and Spine Care.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Organs and Tissue Donation** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transportation.

- **Military and Veterans. If you** are **a member of the armed forces, we may release medical information about you as required by military** command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military **authority.**

- **Workers' Compensation.** We may release medical information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose medical information about you for public health activities.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections and licensure.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose medical information about your response to a court or administrative order, subpoena, warrant, summons, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.

- **Coroners, Medical Examiners and Feral Directors.** We may release medical information to a coroner, medical examiner or funeral director as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services of the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized person or foreign heads of state or conduct special investigations.

- **Inmates.** We may release information about inmates to a correctional institution or law enforcement.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Rights to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Other licensed health care professional chosen by the Privacy Officer will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Center for Pain and Spine Care.

To request an amendment, your request must be made in writing and submitted to Privacy Officer. In addition, you must provide a reason that supports your request

We may deny your request for an amendment if you ask us to amend information not created by us, unless the person that created the information in longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

Rights to an Accounting of Disclosures. You have the right to request an "account of disclosures". This is a list of the disclosure we made of medical information about you.

To request this list or account of disclosures you must submit your request in writing to Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically), The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the lists. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Rights to Request Restrictions, You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment and/or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request **If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.**

To request restrictions, you must make your request in writing to Privacy Officer, CPSC, 3 Hospital Plaza, Suite 313, Old Bridge, NJ 08857. In your request, you must tell us (1) what information you want to limit. (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical *matters in a certain* way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you are to be contacted. We have the right to deny your request

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to leave you a copy of the notice at any time. Even if you have agreed to receive this notice electronically you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, ask any front desk person.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effect for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in Center for Pain and Spine Care. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at our clinic for treatment or health care services as an outpatient, we will offer you copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Center for Pain and Spine Care or with the Secretary of the Department of Health and Human Services. To file a complaint with Center for Pain and Spine Care, contact, Privacy Officer at (732) 360-1800. ALL complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke-that permission, in writing, at anytime. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Center for Pain and Spine Care
3 Hospital Plaza, Suite 313, Old Bridge NJ 08857-3096
732-360-1800 732-360-1807

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for **D.**_____below, you may have to pay. Your insurance _____may not offer coverage for the following services even though your health care provider advises these services are medically necessary and justified for your diagnosis.

We expect _____ may not pay for the **D.** _____

D.	E. Reason Insurane May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to appeal to your insurance company for coverage.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me as an Explanation of Benefits. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to _____.** If _____ does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill _____. You may ask to be paid now as I am responsible for payment.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment.

H. Additional Information:

This notice gives our opinion, not an denial from your insurance company. If you have other questions on this notice please ask the front desk person, the billing person, or the physician before you sign below. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: