Advance Beneficiary Notice (ABN)

Patient Name: ____

Insurance Name/ID #: ____

The purpose of this form is to help you make an informed choice about whether or not you want to receive this/these item(s), knowing that you may have to pay for it yourself at a reduced cost to you.

Your health insurance may not cover the item or items that your Physical Therapist or Certified Athletic Trainer is requesting. All insurance coverage has limitations on covered services and items, and this item may not be covered. This does not mean that you should not have this item, as there is a good reason your clinician is recommending it.

Your insurance may not pay for:

☐ **Item: Disposable E-stim pads. A $7.00/2 pads charge. These e-stim pads are used on you only; they are kept in a sealed bag with your name on them and thrown away when you are discharged from Physical Therapy. (Unless you are here for an extended period of time and your pads become non-adhesive or torn, this is a one-time charge.)**

☐ **Item: Thera-band. A one-time $5.00 charge. This Thera-band is a very important part of your Physical Therapy. This exercise band is for use with your prescribed Home Exercise Program. Performing your Home Exercise Program is a critical step in your rehab and will enhance the exercises you perform in the clinic and speed your recovery time. This is a one-time charge, though throughout your rehab you will be progressed through different colors/resistance of bands, you will pay only one $5.00 charge.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive this item(s), knowing that you may have to pay for it yourself.

☐ **Yes, I want to receive the selected item(s).**
Please submit my claim to my insurance. I understand that you will bill me for this item. If my insurance does pay, you will refund any payments that I may have made for this item. If my insurance denies payment for this item, or does not pay the full amount, I agree to be personally and fully responsible for payment.

_____________________________________ ________________
Signature of patient or guardian **Date**