RADIOLOGY & MRI of Bethlehem, Inc.

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Advance Beneficiary Notice (ABN)

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

We expect that your health insurance will not pay for the item(s) or service(s) that are described below. Your health insurance does not pay for all of your health care costs. Your health insurance only pays for covered items and services when your insurance rules are met. The fact that your health insurance 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 health insurance will 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. Before 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 health insurance probably won't 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 & DATE YOUR CHOICE

☐ **Option 1 - YES. I want to receive these items or services.**

I understand that my health insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my health insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my health insurance is making its decision. If my health insurance does pay, you will refund to me any payments I made to you that are due to me. If my health insurance 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 health insurance'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 health insurance and that I will not be able to appeal your opinion that my health insurance 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 office. If a claim is submitted to your health insurance, your health information on this form may be shared with your health insurance. Your health information which your insurance sees will be kept confidential by your health insurance.

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