P ✝S Chiropractic, Inc.
430 Hampton Ave. Pickens, SC 29671
*Phone (864) 878-8190 ** Fax (864) 878-6800*

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.
We expect that Medicare will not pay for the item(s) or service(s) that are described below over the allotted amount. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There maybe a good reason your doctor recommended it. Right now in your case,

Items or Services:

Chiropractic Adjustment (Chiropractic Manipulative Treatment): 98940, 98941

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Because:

Medicare does not pay for this item or service more often than frequency limit.

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.

- If you do not understand, ask us to explain why Medicare probably will not 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, and date your choice.

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

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services that I may have to pay for while Medicare is making its decision. If Medicare does pay, you will refund me any payments I made to you that are due to me. If Medicare 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 Medicare's decision.

☐ **Option 2. NO I have decided not to receive these items or services.**

Patient Name: ______________________________ Medicare # (HCN):______________

✖ Patient Signature: ____________________________ 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. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Any health information that Medicare sees will be kept confidential.

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Items or Services:

- Consult and examination
- X-rays (X-rays required: To be determined during patient consult/examination)

Because:

Medicare does not pay for this item or service.

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- If you do not understand, ask us to explain why Medicare probably will not 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, and date your choice.

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

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☐ **Option 2. NO I have decided not to receive these items or services.**

Patient Name: ____________________________ Medicare # (HCN):______________

✖ Patient Signature: ____________________________ 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. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Any health information that Medicare sees will be kept confidential.