HEALTH SPHERE WELLNESS CENTER, LLC

5054 Thoroughbred Ln * Brentwood, TN * 37027 * 615-376-7876

Date:________________ Patient's Name:____

ADVANCE BENEFICIARY NOTICE (ABN)
For Medicare Patients Only

NOTE: You need to make a choice about receiving these health care items or services. Medicare (and/or your Insurance Carrier) will not pay for the item(s) or service(s) that are described below. Medicare (and/or your Insurance Carrier) does not pay for all of your health care costs. Medicare (and/or your Insurance Carrier) only pays for covered items and services when Medicare (and/or your Insurance Carrier) rules are met. The fact that Medicare (and/or your Insurance Carrier) will 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, **Medicare (and/or your Insurance Carrier) will not pay for –**

Items or Services:
Annual subscription fee for non-covered health care services.
Because:
Medicare (and/or your Insurance Carrier) will not pay for services that are not under their description of covered services. Participation in a limited enrollment practice, and non-covered health care services are not recognized by Medicare (and/or your Insurance Carrier) as covered services.

This means if you have a deductible that has not been met or a co-insurance, it's your responsibility to pay. Physical therapy is a covered service of Medicare. Most other insurance companies have Physical therapy benefits. You may call your insurance company to verify how much will be paid.

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 Medicare (and/or my Insurance Carrier) will not pay for these services. I agree to be personally and fully responsible for payment.

☐ **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 Medicare (and/or my Insurance Carrier) and that I will not be able to appeal your opinion that Medicare (and/or or my Insurance Carrier) 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 Medicare (and/or your Insurance Carrier), your health information on this form may be shared with Medicare (and/or your Insurance Carrier). Your health information which Medicare (and/or your Insurance Carrier) sees will be kept confidential by Medicare (and/or your Insurance Carrier).