VISION & SENSORY INTEGRATION INSTITUTE

Pretreatment/Sensorimotor Exam

ADVANCE BENEFICIARY NOTICE (ABN)

Patient Name: **Date:**

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

We expect that insurance/ Medicare will not pay for the item(s) or services(s) described below. Insurance/Medicare does not pay for all of your health care costs. Insurance only pays for covered item(s) and service(s) when insurance/Medicare rules are met. The fact that insurance/Medicare may not pay for a particular item(s) or service(s) does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **insurance / Medicare probably will NOT pay for**:

Item(s) or Service(s):	Estimated Cost:
❑ **99213 - Evaluation & Manage Level 3**	$ 150.00
❑ **92083 - Visual Field-Threshold**	$ 150.00
❑ **92060 - Sensorimotor Exam**	$ 200.00
Reason(s):	**Not covered by insurance.**

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 any decision about your options, you should:

- **Read this notice carefully, and in its entirety.** Ask us to explain, if you don't understand why your insurance/Medicare probably won't pay. Ask us how much these items/services will cost you Total (Estimated Cost of $500.00) in case you have to pay for them yourself.

OPTIONS: PLEASE CHECK ONLY ONE BOX (we cannot choose a box for you).

❑ **OPTION 1. YES, I want to receive these items or services.**

I understand that my insurance/Medicare will not decide whether to pay unless I receive these items or services. I understand that you may bill me for items or services, and I may have to pay the bill while insurance/Medicare is making its decision. If insurance/Medicare does pay, you will refund to me any payments I made to you that are due to me. If insurance/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/Medicare I have. I understand I can appeal my insurance/Medicare company'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 insurance and that I will not be able to appeal your opinion that insurance/Medicare won't pay.

By signing below, you have received and understand this notice, and are entitled to receive a copy.

Signature: **Date:**

NOTE: Your health insurance 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 your insurance/Medicare, your health information on this form may be shared with the insurance carrier. Your health information that the insurance company sees will be kept confidential by that insurance carrier/Medicare.

Form CMS-R-131 (01/11) **Form Approved OMB No. 0938-0566**

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