Patient's Name: _____ D.O.B._____

ADVANCE BENEFICIARY NOTICE (ABN)

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

We cannot guarantee payment from your medical insurance for the item(s) or service(s) that are described below. The fact that your medical insurance may not pay for a particular item or service does not mean that you should not receive it.

Your medical insurance may not pay for: VASECTOMY
Because it may not be a covered benefit

The purpose of this form is to help you make an informed choice about whether or not you want to receive this service, knowing that you may be responsible for paying it 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 medical insurance may not pay.
• Ask us how much this service will cost you (**Estimated Cost: $955-1225.00 + Laboratory fees)** in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option1. YES. I want to receive this service.** I understand that my medical insurance may delay their decision as to whether or not to pay until after I receive this service and the claim has been submitted. I understand that you may bill me for items or services and that I may have to pay the bill while my medical insurance is making its decision. If my medical insurance does pay, you will refund to me any payments I have made for this service. If my medical 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 medical insurance's decision.

☐ **Option2. NO. I have decided not to receive this service.** I understand that you will not be able to submit a claim to my medical insurance and that I will not be able to appeal your opinion that my medical 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 offices. If a claim is submitted to your medical insurance, your health information on this form may be shared with them. Your health information which your medical insurance sees will be kept confidential by your insurance.