

**ADVANCED SURGICAL CENTER  
ADVANCE BENEFICIARY NOTICE (ABN)**

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

We expect that your insurance may not pay for the item(s) or services(s) that are described below. Insurance does not pay for all your health care costs. Insurance only pays for covered items and services when your insurance company rules are met. The fact that 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, **Insurance may not pay for-**

**Items or Services:**

IMPLANTS TO INCLUDE, BUT NOT LIMITED TO: PLATES, SCREWS, CLIPS WIRE, ANCHORS, BONE MATRIX & PRP INJECTIONS. (PROTEIN RICH PLASMA) TENEX BLADES OR ANY SPECIAL SUPPLIES MY DOCTOR HAS REQUESTED.

Because: THESE ARE SPECIFIC EXCLUSIONS FOR SOME INSURANCE POLICIES. SOME INSURANCE COMPANIES REQUIRED A MINIMUM AMOUNT BEFORE THEY WILL PAY, OTHERS PLACE CAP ON THE AMOUNTS THEY WILL PAY.

The purpose of this form is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. Before you decide about your options, **please read this entire notice carefully.**

- Ask us to explain if you don't understand why your insurance may not pay.
- Ask us how much these items or services will cost you 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 insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my 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 that I can appeal my insurance companies' decision.

\_\_\_\_\_ Option 2 NO- I have not 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 won't pay. I also understand with this choice that my surgeon will be notified and my procedure may need to be cancelled.

Date

---

Signature of patient or person acting on patient's behalf