Webb Chiropractic
Dr. Kurt K. Webb
671 First Street, Lincoln CA 95648

Patients' Name _____ Medicare # (HICN) _____

ADVANCE BENIFICIARY 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 items or services that are described below. 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 may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for-**

Items or Services:
1. Myofascial Release 2. Examinations 3. X-Rays 4. Exercise Therapy
Because: Medicare does not pay for this item or service more often then 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

*Ask us to explain, if you don't understand why Medicare probably won't 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 AND DATE** YOUR CHOICE.

Option 1. YES. I want to receive this item or services. I understand Medicare will not decide whether to pay unless I receive this items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If medicare does pay, you will refund to 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. I will not receive these items or services. I understand that you wont be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date_____ Signature of Patient of person acting on patients 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, Your health information ion this form will be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

PH: (916)434-0600 FX: (916)434-0603