ADVANCED BENEFICIARY NOTICE

NOTE: You need to make an informed decision about receiving these services

There is always the possibility that your insurance company may not pay for these services. Insurance companies do not always cover mental health treatments. The fact that your insurance company may not pay for these services does not mean that you should not receive the treatment.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these 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 your insurance company may not pay.
- Ask us how much these services will cost you (Estimated cost $_____) in case you have to pay for them yourself or through other means.

☐ OPTION 1: **YES**. I want to receive these services for mental health treatment.

I understand that my insurance company may decide not to pay for these services. Please submit my claim to the insurance company. I understand that you may bill me for services and that I may have to pay the bill while my insurance company is making its decision..

If my insurance company does pay, you will refund to me any payments I made to you that are due to me. If my insurance company denies my claim, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other means that I have. I understand I can appeal my insurance company's decision.

☐ OPTION 2: **NO**. I have decided not to receive these services.

I will not receive these services. I understand that if my insurance company denies the claim that I will have to pay for the service out of pocket. I elect at this time to forgo services even though you have indicated to me that treatment would be beneficial to me at this time. I understand that I may return at any time to reconsider receiving mental health treatment.

_____ _____

Date signature of client or person acting on client'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 insurance company, your health information on this form may be shared with them. Your health information which the insurance company sees will be kept confidential by them as required by HIPAA laws.