CORE Professional Services, P.A. Medicare Advanced Beneficiary Notice of Noncoverage (ABN)

Patient Name: _____ **DOB:** _____

The client portion of your bill is due on the date of service unless other arrangements are made and agreed upon by the business office. Although we will bill insurance, it is the client's responsibility to check with their insurance company regarding any co-payment, deductible, or percentage of fee for which the client may be responsible. Questions regarding your bill should be directed to the billing department at (218) 829-7140.

I authorize the release of any medical or other information necessary to process my account at CORE Professional Services, PA. I authorize that information regarding my therapy may be submitted to my insurance company to process any claims. I request payment of medical benefits from either a governmental or non-governmental insurance provider to be issued to CORE Professional Services, PA. I understand that I am ultimately responsible for my account balance. In the event my insurance benefits do not pay for fees incurred at CORE Professional Services, PA the balance of my account will be my liability. Not all insurances pay for every service. Your insurance may not pay for the service listed below.

Services	Reason Insurance May not Pay:	Estimated Cost
☐ Diagnostic Interview ☐ Psychological Testing ☐ Individual Psychotherapy ☐ Group Psychotherapy ☐ Family Psychotherapy ☐ Other _____ _____	a. insurance may determine service is not "medically necessary" b. non-covered service c. diagnosis code may not be covered under policy provisions d. court-ordered services are not covered under policy provisions e. other (explain):	

What you need to do now:

- ✓ Read this notice, so you can make an informed decision about your care.
- ✓ Ask us any questions that you may have after you finish reading.
- ✓ Choose an option below about whether to receive the services listed above (D).

Options: Check only one box. We cannot choose a box for you.

☐ **Option 1.** I wish to continue with the services listed above. You may ask to be paid now, but I also wish to have my insurance billed for an official decision on payment. I understand that if my insurance denies, I am responsible for payment. I may try to appeal the decision with my insurance company directly. If insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance and deductibles.

☐ **Option 2.** I wish to continue with the services listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal to my insurance if no claims have been billed/submitted.

☐ **Option 3.** I don't want the service listed above. I understand with this choice I am not responsible for payment.

This notice gives our opinion, not an official insurance decision. Signing below means you have received and understand this notice. You may also request a copy.

Signature:_____ **Date:** _____

(Client or Authorized Person and Relationship)

Do you have a Health Care Directive? _____ YES _____ NO

*If no, do you wish to receive information on this? _____ YES _____ NO

Primary Care Physician: _____ Practicing Location: _____

*If you wish for records to be sent to your primary care physician, please request to sign a release of information.

Mental health services are available by two-way interactive video or audio communications, referred to as "telemedicine" or “telehealth,” which means that you may be evaluated and treated by a health care provider or specialist from a different location.

1. You must inform your provider if anyone is required to be present with you at your location, and you may give your verbal permission prior to the start of a session authorizing additional personnel to be present in the room with your provider, such as another provider, intern, etc. You may request that nonessential personnel leave the room(s) at any time to allow a private consultation with your provider
2. The therapist for whom the on-site examination or treatment is performed will keep a record of the encounter in your medical record.
3. If you participate in sessions through telehealth, you understand that you must be alone in a private location for this to occur. If there is any instance of breaking confidentiality of other participants, you may be immediately terminated.
4. You are not allowed to audio record or videotape any virtual group or individual session.
5. You must participate from a location within the state lines.

Noting all the above, you understand that your participation in telehealth services is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data. By signing this form, you acknowledge that the providers involved have explained the telehealth encounter in a satisfactory manner and that all questions that you may have about the telehealth encounter have been answered satisfactorily. Understanding the above, I consent to the telehealth process described above.

Signature:_____ Date: _____

(Client or Authorized Person and Relationship)