

Houston Gastroenterology Associates

Patient Name: _____

Date of Birth: _____

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 service(s) that are described below. Your insurance does not pay for all of your health care costs. Your insurance only pays for covered items and services when your insurance rules are met. The fact that your 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, **your insurance may not pay for-**

Items or Services: Colonoscopy

Because: Insurance Termination, Pre-Existing Condition, Policy Rider or Exclusion, Non-Covered due to global limits, Due to Medical Necessity, and Routine or Preventative Services not covered.

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 your insurance may not pay.
- Ask us how much these items or services will cost you.

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 company 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 does pay, you will refund to me any payments I made to you that are due to me. I understand my colonoscopy will be performed for colon cancer screening. If a colon polyp or other pathology is identified during the procedure, I am aware this information must be submitted to my insurance carrier, which may, in turn, apply additional deductible and coinsurance that will be my responsibility to pay. 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 I can appeal my insurance companies' 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 will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my 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 insurance company, your health information on this form may be shared with your insurance company. Your health information which your insurance company sees will be kept confidential by your insurance company.