Name of Practice
Address, Phone, web information

Advanced Notice and Agreement of Patient Financial Responsibility
(Voluntary Beneficiary Notice)

Patient Name: DOB:

Your doctor has recommended the following treatment plan to facilitate the best recovery from your current condition. The expected advantages of receiving care and the disadvantages of not receiving care have been discussed with you and you have indicated he/she has adequately answered any questions you may have.

Unfortunately, each insurer has different opinions about what care is and is not medically necessary. This makes it difficult to accurately determine the amount that will be reimbursed by the insurer and the amount for which the patient is responsible for payment until the insurer processes the claim and makes payment. The resources required to render the care and appeal their decisions exceed the potential reimbursement.

Treatment Plan and Estimated Costs

I want this service (Patient Initials)	**Service**	**Frequency**	**Duration Begin/End Date** (Estimated)	**Estimated Cost if Billed to Insurance**	**Estimated Cost if Prepaid / Paid at Time of Service**

Options

Do you want the services you have initialed? Yes / No Do you want your insurer(s) billed? Yes / No Medicare Advantage Plan Yes / No Other insurer Do you understand you are financially responsible for charges not paid by your insurer? Yes / No	
	I want the services that I have initialed. Please bill my insurer. I accept financial responsibility for services not paid by my insurer.
	I want the services that I have initialed. Do NOT bill my insurer. I accept full financial responsibility
	I do not want the services I have not initialed

Additional Information:

_____

_____

_____

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

A copy of this form is given to the patient at the time it is signed.