Advanced Spine Care PA
State-of-the-Art Spinal Therapy

We expect that your insurance will not pay for the item(s) that are described below. Your insurance does not pay ALL of your health costs. Your insurance only pays for covered items when the insurance rules are met. The fact that your insurance may not pay for a particular item 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 □ Medicare □ Other may not pay for:
Decompression on the Accu-Spina System

Because: Your insurance may consider it Not Medically Necessary

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items, features, or upgrades knowing that you might have to pay for them yourself. Before making a decision about your options, you should read this entire notice carefully.

Ask us to explain, if you don't understand why your insurance probably won't pay.

Ask us how much these items or services will cost you (estimated cost - $1,500) in case you have to pay for them yourself or through another insurance.

Please Choose One Option. Check One Box. Sign and Date Your Choice.

□ **YES**, I want to receive treatment on the Accu-Spina System.
I understand that my insurance will not decide whether to pay unless I receive these items. Please submit my claim to my insurance. I understand that you may bill me for the items 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. 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 company's decision.

□ **NO**, I have decided NOT to receive treatment on the Accu-Spina System.
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

Patient's Name:_____

Insurance ID:_____

Signature:_____

Date:_____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance company. The health information which your insurance company sees will be kept confidential by your insurance company.