A. **Notifier:** Johnson Chiropractic & Holistic Health Center, LLC – 908 Rain Forest Parkway, Suite B, Columbia, MO 65202

B. **Patient Name:** ______________________ C. **Medicare ID Number:** ______________________

Advance Beneficiary Notice of Non - Coverage (ABN)

Medicare does not pay for everything, even care that your doctor deems medically necessary. We expect Medicare may not pay for the **D. *Non-Covered Services*** below:

(**NOTE:** If Medicare does not pay for **D. *Non-Covered Services*** below, you may have to pay)

D. Non – Covered Services	E. Reason Medicare May Not Pay	F. Estimated Cost
1. Exams and Re-Exams	Medicare Will NOT Pay For Any Services Besides 80% of *Chiropractic Manipulative Treatment* for active treatment of an acute problem or exacerbation of a chronic problem, only after your Medicare deductible is MET.	$25
2. Traction Therapy		$5
3. Electrical Muscle Stimulation		$10
4. Acupuncture		$45 or Chiropractic Copay plus $25
5. Chiropractic Maintenance Care		$45 per visit

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 **D. Non-Covered Services** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.
Treatment cannot be administered without an Exam. If you choose option 3 you are indicating you do not wish to receive treatment

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

☐ **Option 1**: I, the patient, want the **D. *Non-Covered Services*** listed above. I may ask to be paid now, but I also want Medicare to be billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does NOT pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you, Johnson Chiropractic, will refund any payments I made to you, less co-pays or deductibles.

☐ **Option 2**: I want the **D. *Non-Covered Services*** listed above, but do not bill Medicare. I *may be asked to pay now* as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **Option 3**: I Do Not want the **D. *Non-Covered Services*** listed above. I understand with this choice I am **not** responsible for payment, and I **cannot appeal to see if Medicare would pay.**

H. This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may also request a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.