D-RAD MOBILE IMAGING
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Advance Beneficiary Notice (ABN)

Commercial Insurance/Out of Network

Patient Name:	**Insurance ID#:**
Patient DOB:	

NOTE: YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THESE HEALTHCARE ITEMS OR SERVICES.

We expect that your insurance company will process the claim for the services that are described below. Your insurance company may not pay for all of your healthcare costs. Your insurance company only pays for covered items and services. The fact that your insurance company many not pay for a particular item or service does not mean that you should not receive it. There may be good reason that your doctor has recommended the specified service. Right now, in your case, your insurance company may not pay for:

Item or Service: Diagnostic X-Ray Services
Because: You will be responsible for the cost share portion of this claim to include Co-pay, Co-insurance, Deductible or Out-Of-Network benefits as a patient it is your responsibility to know your benefits. If we are out of network with any insurance you will be responsible for any balance brought forward by your insurance.

The purpose of this form is to help you make an informed decision about whether or not 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 document carefully.

- Ask us to explain, if you DO NOT understand why your insurance company may not pay.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE:

❑ **OPTION 1: YES, I WANT TO RECEIVE THESE ITEMS OR SERVICES.**
I understand that my insurance company will NOT pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for the items or services AND that I may have to pay the bill while my insurance makes a decision. If my insurance company DOES pay, any money paid for the specified services will be refunded to me. If my insurance company DENIES payment, I agree to be personally and fully responsible for the payment. I agree to pay personally, out of pocket or through any other insurance that I have. I understand that I can appeal the denial to my insurance company.

❑ **OPTION 2: NO, I HAVE DECIDED NOT TO RECEIVE THESE ITEM 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 the option that my insurance company will NOT pay.

Signature of the patient or person acting on patient's behalf **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 offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.