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PATIENT'S NAME: ADVANCE BENEFICIARY NOTICE (ABN) Medicare/Insurance# (HICN):

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 according to the Privacy Policy you have previously reviewed.

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare/Your (My) Insurance Co. (YIC) (MIC) will not pay for the item(s) or services that are described below. Medicare/YIC does not pay for all of your healthcare costs. Medicare/YIC only pays for covered items and services when Medicare/YIC rules are met. The fact that Medicare/YIC 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, **Medicare/YIC will probably not pay for these items or services:**

A. Prolonged Physician Service **with** direct (face to face) patient contact. [99354 – 99357]

Estimated Cost:

\$500.00 / 90-134 minutes for an initial visit
\$250.00 / 70-114 minutes for a follow-up visit
\$250.00 each additional 30 minutes.

B. Prolonged Physician Service **without** direct (face to face) patient contact. [99358 – 99359]

Estimated Cost:

\$250.00 / 30-74 minutes,
\$200.00 each additional 30 minutes

C. Team Conferences. [99366 – 99368]

Estimated Cost:

\$250.00 / 30 minutes,
\$250.00 / 31-60 minutes,
\$200.00 each additional 30 minutes

D. Cancellations (less than 24 hours prior to the appointment).

Estimated Cost: \$250.00

E. Telephone Calls & E-Mails. [99441 – 99444]

Estimated Cost:

\$125.00 / every 15 minutes

F. Thermography. [93760 - 93762]

Estimated Cost:

\$300.00 / Cephalic or Region of Interest
\$450.00 / ½ Body,
\$600.00 / Whole Body

G. Preventive Medicine Services. [99381 – 99397]

Estimated Cost:

\$250.00 / 1-30 minutes,
\$250.00 / 30-74 minutes,
\$200.00 each additional 30 minutes

H. Home Services. [99341 – 99350]

Estimated Cost:

\$750.00 / 1-30 minutes,
\$500.00 / 30-74 minutes,
\$375.00 each additional 30 minutes

I. Basic Life and/or Disability Evaluation Services. [99450]

Estimated Cost:

\$500.00 / 1-30 minutes,
\$250.00 / 30-74 minutes,
\$200.00 each additional 30 minutes

J. Work Related or Medical Disability Evaluation Services. [99455 - 99456]

Estimated Cost:

- \$500.00 / 1-30 minutes,
- \$250.00 / 30-74 minutes,
- \$200.00 each additional 30 minutes

K. Other Evaluation and Management Services. [99420 – 99429]

Estimated Cost:

- \$500.00 / 1-30 minutes,
- \$250.00 / 30-74 minutes,
- \$200.00 each additional 30 minutes

L. Counseling and/or Risk Factor Reduction Intervention [99401 – 99412]

\$100.00 / every15 minutes

M. Supplements: Varying prices [99070]

N. Collection and Handling. Cost: \$25.00 / Lab Test

O. Alternative/Nutritional/Anti-Aging Medicine \$500.00/hour

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 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 Medicare (YIC) probably won't pay.

OPTION 1. YES I want to receive these items or services. I understand that Medicare (MIC) will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare (MIC). I understand that you may bill me for items or services and that I may have to pay the bill while Medicare (MIC) is making its decision. If Medicare (MIC) does pay, you will refund to me any payments I made to you that are due to me. If Medicare (MIC) 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 Medicare's (MIC's) decision.

OPTION 2. NO I have decided not to receive these items services. I understand that is my responsibility not to receive these items or services and that you will not be able to submit a claim to Medicare (MIC) and that I will not be able to appeal your opinion that Medicare (MIC) won't pay.

PLEASE CHOOSE ONE OPTION CHECK ONE PARENTHESIS. SIGN & DATE YOUR CHOICES FOR EACH ITEM OR SERVICE:

	<u>OPTION 1 YES</u>	<u>OPTION 2 NO</u>	<u>INITIAL</u>	<u>DATE</u>
A. Prolonged Physician Service with direct (face to face) patient contact.	A. ()	A. ()	A.____	A.____
B. Prolonged Physician Service without direct (face to face) patient contact.	B. ()	B. ()	B.____	B.____
C. Team Conferences.	C. ()	C. ()	C.____	C.____
D. Cancellations (less than 24 hours prior to the appointment)	D. ()	D. ()	D.____	D.____
E. Telephone Calls & E-Mails	E. ()	E. ()	E.____	E.____
F. Thermography	F. ()	F. ()	F.____	F.____
G. Preventive Medicine Services	G. ()	G. ()	G.____	G.____
H. Home Services	H. ()	H. ()	H.____	H.____
I. Basic Life and/or Disability Evaluation Services	I. ()	I. ()	I.____	I.____
J. Work Related or Medical Disability Evaluation Services	J. ()	J. ()	J.____	J.____
K. Other Evaluation and Management Services	K. ()	K. ()	K.____	K.____
L. Counseling and/or Risk Factor Reduction Intervention	L. ()	L. ()	L.____	L.____
M. Supplements	M. ()	M. ()	M.____	M.____
N. Collection and Handling	N. ()	N. ()	N.____	N.____
O. Alternative/Nutritional/Anti-Aging Medicine	O. ()	O. ()	O.____	O.____

Date _____ **X**
(Signature of the patient or person acting on patient's behalf)