

Patient's
Name: _____

Insurance
Carrier: _____

Universal Advance Beneficiary Notice (UABN)

The purpose of this form is to help you make an informed choice about whether or not you want to receive our services, knowing that you might have to pay for them yourself.

From time to time some insurance carriers refuse to pay patient insurance claims for different reasons; *examples*: if your employer has not kept up on the premiums, or they (*the insurance carrier*) disagree with the type of service(s) to be performed.

Insurance carriers will not pay all your health care costs. The fact that your insurance carrier may not pay for a particular service(s) does not mean that you should not receive it. There may be a good reason your doctor recommended it.

I understand that my insurance carrier may refuse to pay for certain services.
I understand that you will bill me for services that I will have to pay while my insurance carrier is making its decision. If my insurance carrier does pay, you will refund to me any payments that are due me. If my insurance carrier denies payment, I agree to be personally responsible for full payment.

YES, I want to receive these services.

Signature of patient or person acting on the patient's behalf

Date