A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

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.** _____ 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.

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

OPTION 1. I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

OPTION 3. I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

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 also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Farahmand Plastic Surgery
12411 Brantley Commons Ct
Fort Myers, FL 33907
Office 239-332-2388/Fax 239-332-2382

INSURANCE FINANCIAL POLICY

AUDREY FARAHMAND, M.D.

This document is designated to inform Dr. Audrey Farahmand's patients of our expectations for payment. Payment is expected at the time of service (Cash, Check American Express, Visa, MasterCard and Discover are accepted). If you have insurance coverage that Dr. Farahmand is a provider for, we will file your insurance claims for you and collect a co-payment or deductible at the time of service. If we are not a provider for your insurance, we will expect payment at the time of the service. We will be glad to provide a receipt and a claim form for you to send to your insurance company. For Medicare patients we will file and if you have a secondary insurance plan our billing company will send it on to your second insurance as a courtesy. We will then bill you for any unpaid balance due.

Patient signature: _____ Date:_____

Guarantor: _____Date:_____

Employee Witness:_____Date:_____

Farahmand Plastic Surgery
12411 Brantley Commons Ct
Fort Myers, FL 33907
Office 239-332-2388/Fax 239-332-2382

AUTHORIZED AGREEMENT

AUDREY FARAHMAND, M.D.

- When assignment is accepted. I hereby authorize my insurance company to pay the proceeds of any benefits due to me to the doctor directly. (Including Medicare benefits or major medical).
- Upon receipt of a request for release of medical information, I hereby authorize the above named physician to release information acquired in the course of my examination or treatment.
- I hereby authorize any physician, hospital, or medical care facility to provide information on my medical history and treatment to the above name physician.
- I hereby authorize any holder of medical or other information (regarding myself) to be released for Medicare or CMS claims to the following: the social security administration, the state of Florida, their intermediary or fiscal agent.
- I hereby authorize the above named physician to receive "explanation of Medicare benefits" advisement (for non-assigned Medicare Claims) on my behalf direct from the Medicare intermediary.
- I hereby certify that the information given by me in applying for payment under the Medicare program is correct.
- I hereby authorize photocopies of this form to be as valid as the original.
- Photograph consent form: I hereby grant permission for the doctor to take photographs of me to use for documentation in the doctor's records and/or to submit to my insurance carrier for prior authorization for surgery or proof of disability. These photographs may be used for educational purposes (i.e. publications, internet, and/or lectures both on national, state and local levels).

Patient Name (Print):_____

Patient Signature:_____

Date:_____