New England Center
for healthy minds

Exceptional People, Extraordinary Care, Easy Access

Patient Name: ____

Date of Birth: ____

Insurance Co: ____

Advance Beneficiary Notice (ABN)

Note: You will need to make a choice about receiving these healthcare items or services.

Your health insurance may not pay for the item(s) or service(s) that are described below. The plan that you have chosen as your health insurer does not necessarily cover all of your healthcare costs. Insurance may only pay for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive the service.

Item(s) or service(s):

Estimated cost:

Description:

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for the items yourself. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s).

Responsible Party Signature: ____

Date: ______________________