Patient's Name:_____ **DOB:**_____

Advance Beneficiary Notice (ABN)

NOTE: Please make a choice about receiving Kodiak Cold Therapy Unit & Pad.

Your insurance may not pay for the Kodiak Cold Therapy Unit & Pad. Insurance companies do not pay for all of your health care costs. Insurance companies only pay for covered items and services when their rules are met. The fact that your insurance may not pay for this item does not mean that you should not receive it. Your doctor recommends this to help with post operative swelling and inflammation and as a convenience to you.

The purpose of this form is to help you make an informed choice about whether or not you want to receive the Kodiak Cold Therapy Unit & Pad, knowing that you may have to pay for it 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 insurance may not pay.
- Ask us how much this item will cost you (**Estimated Cost: $300**).

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive the Kodiak Cold Therapy Unit & Pad. ($300)

☐ I understand that my insurance may not pay for this item. I understand that I may have to pay for this item myself. I agree to be personally and fully responsible for payment. I understand that if my insurance does pay, I will be refunded any payments that were made for this item.

Office Use Only: Knee Pad Shoulder Pad XL Shoulder

☐ **Option 2. NO. I have decided not to receive the Cold Therapy Unit & Pad.**

I will not receive this item. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance company will not pay.

_____

_____

Date **Signature of patient or person acting on patient's behalf**

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.