

ELLE MEDICAL - ADVANCE BENEFICIARY NOTICE (ABN)

Patient's Name: _____ Date: _____
Patient Social Security Number _____ - _____ - _____
Date of Birth: _____

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 that you will have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

NOTE: You need to make a choice about receiving these health care items or services. We expect that your health insurance company will not pay for the item(s) or service(s) that are described below. Your health insurance company does not cover all or pay for all of your health care costs. Your health insurance company only pays for ***covered*** items and services when your health insurance company rules are met. The fact that your health insurance company 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, **your health insurance company probably will not pay for the following items or services: (CHECK ALL THAT APPLY)**

- Complimentary and/or Alternative Medical Evaluation and/or Treatment
- Acupuncture Therapy
- Bio-Identical or Natural Hormone Therapy
- Vitamin Therapy
- VIP Executive Preventative Evaluation and Physical Examination*
- Nutritional Therapy or Counseling
- Laser Treatments or Photo Therapy
- Guided Imagery, Relaxation or Mind/Body Therapy
- Massage Therapy or Spa Treatments

Because: The services and products known as Complimentary and Alternative are *not* covered benefits covered under any Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network (BCN) policy, certificate or rider or any other insurer.

- Ask us to explain, if you don't understand why your health insurance company probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost:** _____.)

ON THE REVERSE SIDE OF THIS PAGE, PLEASE FIND AND CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

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Option 1. YES. I want to receive these items or services. I understand that my health insurance company will most likely deny payment for these services since these are not covered benefits. I agree to be personally and fully responsible for payment. That is, I will pay personally out of pocket for non-covered items and services rendered at this facility such as those rendered specifically arising from the special training Dr. Levine has acquired by the American Board of Holistic Medicine and, as such, I will be responsible for paying for such services at the time they are provided. I accept that natural and holistic or complimentary and alternative services will not be billed for reimbursement. In addition, I agree not to submit receipts for such items or services for reimbursement as benefits under my insurance plan. I understand that this facility has not provided me with diagnosis codes or procedure codes or other such billing information due to the fact that billing codes do not exist for complimentary and alternative medicine (CAM), holistic care, alternative medicine or spa services.

Option 2. NO. I have decided not to receive these items or services. I will not receive items or services that are non-covered. The services that are specifically rendered known as complimentary and alternative medicine (CAM) arising as a result of Dr. Levine's special training acquired by the American Board of Holistic Medicine are hereby declined. I have been given the option and opportunity to obtain **covered** items and services that are considered benefits under my health plan by Dr. Levine as a contracted provider and as such, I will be provided only with **covered** benefits under my insurance plan.

In the event that my insurance will be billed for covered services under my health plan for covered services, I hereby authorize Elle Medical to charge my credit card on file for my co-pay or deductible as appropriate.

Signature of patient or person acting on patient's behalf

Witness

Date

** VIP Executive Preventative Evaluation and Physical Examination is a separately billed non-covered service (distinctly different from a routine annual physical examination) and may include additional items such as an exclusive private office setting, medical record critical diagnostic analysis, electronic pharmaceutical interaction evaluation – medication reduction, exclusive private literary research, comprehensive wellness and lifestyle planning exclusive time slots special held appointment times, house-call availability, on time appointments – minimal waiting exclusive prescription “No-Refill Necessary” Program and enhanced coordination of care (calls to get you into a specialist or special testing such as CT, MRI etc.)*