Anderson-Smith
SPEECH THERAPY LLC

Advance Beneficiary Notice

Anderson-Smith Speech, Feeding and Myofunctional Therapy LLC uses a treatment model that emphasizes family support and participation. We count on participation from the client and the family during the therapy process including observation, techniques for daily carryover, and commitment to home practice. We typically bill an office visit with treatment as this is the CPT Evaluation and Management procedure that covers counseling and family training. Your insurance will only pay for covered services under your policy and/or under the determination of a medical review. The fact that your insurance may not pay for a particular **diagnosis, procedure, or service** does not mean that you should not receive it, that it isn't medically necessary, or that it is not within the scope of practice of our profession. There are valid reasons for a therapist to recommend particular services and procedures based on evaluation results, which might not meet the criteria in your individual policy.

Although we have checked your benefits, nothing is guaranteed, therefore insurance may not pay for:

92523 Eval Language/Artic	96125 Eval Cognition	97129 Therapy Cognition
92524 Eval Voice and Resonance	96112 Eval Development	92507 Therapy Language/Artic
92610 Eval Oral Function	92521 Eval Fluency	92609 Therapy AAC
92607 Eval AAC	99211 E/M Est. Patient	92526 Therapy Oral Function
92522 Eval Artic/Apraxia	99212 E/m Est. Patient	99201 E/M New Patient
97167 OT eval high complex	97165 OT Eval low complex	97166 OT eval mod complex
97110 Therapeutic exercises	97530 Therapeutic activities	97168 OT re-eval est plan care

Because:

- Policy Limitations or Exclusions
- Delay Due to Medical Review
- Your Policy's Definition of Medical Necessity
- Our insurance contracts may not cover out of clinic contact

The purpose of this form is to help you make an informed choice, knowing that you will have to pay for services billed at the self-pay rate

- If insurance has informed us this is not a covered benefit
- If we continue with therapy while insurance does a medical review
- If insurance determines, after initially approving treatment, that it is an uncovered benefit under your plan (in which case, you are also responsible for any payments your insurance recoups from us).

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Ask us to explain if you do not understand why insurance may not pay.

Ask us to provide an estimated cost to you of these services.

In accordance with our contract with your insurance company, we need to be sure you make an informed choice about receiving and paying for non-covered services, procedures, and diagnoses.

Please Choose an Option:

_____ **YES** I want to receive services as listed above. I understand that my insurance may decide not to pay for these services for any reason. Please submit my claims to insurance. I understand that you may bill me for items or services not covered or that I may have to pay the bill if there is a delay while insurance is making a decision if the treatment goes to medical review or if the insurance company misplaces submitted medical records. I agree to immediately pay any balance on my account for claims that are 30 days from the date of service. If my insurance company does pay you, you will refund me any payments that I have made to you that are due to me. If insurance denies payment, I agree to be personally and fully responsible for payment of the initial service and any recommended treatment that I choose to continue. That is, I will pay out of pocket for the initial claim, and at the time for service for any additional treatment. I understand that I can reverse my agreement to pay for continued services by notifying the office 24 hours prior to treatment.

_____ **NO** I have decided not to receive these services.

_____ _____ _____

Signature of Financially Responsible Party Client Name Date