DelRay Maughan, M.D.
James V. Crawford, MD

ADVANCED BENEFICIARY NOTICE

Patient Name:_____

Patient Account:_____ Date of Service:_____

You are scheduled for a procedure that is not payable or covered by insurance. Our physicians perform procedures based on medical necessity to treat your condition. Your insurance considers this procedure experimental and is a non-covered service. The purpose of this form is to help you make an informed decision about whether or not you want to receive this service knowing that you will be fully responsible for the agreed cost.

Procedure(s):_____

Estimated Cost(s):_____

I understand that the above procedure(s) is not a covered benefit and **will not** be billed to my insurance. I agree to be personally and fully responsible for payment of this service on the date the procedure is performed.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Employee Date

*Please scan this signed agreement into the patient's record. *