105 Collier Road Suite 4060 Atlanta, Georgia 30309 404.351.6662 f 404.351.6030 www.piedmontpediatrics.org

Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: _________________________ Date of Birth: _______________________
Account #: ______________________

Note: Your health insurance company may not cover all or pay for all of your health care costs. Your insurance company only pays for **covered** items and services when your insurance company rules are met. **Your health insurance company may or may not pay for the following services or items. Prior verification of benefits is not a guarantee of payment. Please refer to your benefits manual for detailed information about your individual coverage.**

Services provided:

- Office Visit/Consultation
- Environmental Allergy Testing
- Pulmonary Services
- Preparation of Allergy Serum
- Allergy Injection
- Feno Testing
- Other services as necessary

Beneficiary Agreement

I, _______________________________, acknowledge that I have read the information above and understand that I will be fully responsible for any account balance resulting from both covered (deductible, co-pays and co-insurance) and non-covered services.

____ ________________________

Signature of Beneficiary or Person Acting on Behalf of Beneficiary Date

Relationship to patient • Same • Parent/Guardian

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Provider Representative