A. Notifier: Galena Sport Physical Therapy

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your insurance doesn't pay for **D. Dry Needling** below, you may have to pay. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Insurance may not pay for the **D. Dry Needling** below.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
Dry Needling	Not a covered service	$10

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Dry Needling** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Dry Needling** listed above. You may ask to be paid now, but I also want Insurance billed for an official decision on payment, which is sent to me on a Insurance Summary Notice (MSN). I understand that if Insurance doesn't pay, I am responsible for payment, but I can appeal to Insurance by following the directions on the MSN**.** If Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Dry Needling** listed above, but do not bill Insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if Insurance is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Insurance would pay.

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: