



ANWAN Wellness Medical Centers P.C.

Pediatrics + Internal Medicine + Preventive Medicine + Anti-Aging
+ Gastroenterology + Geriatrics + Physical Therapy + Podiatry

Patient's Name: _____ Date: _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE:

You need to make a choice about receiving these health care items or services. 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 might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**. We expect that your insurance may not pay for the item(s) or service(s) that are described below:

- FIA (Comprehensive Nutritional Panel)** \$160 fee for service or \$595.00 cash price
- IMMUNO LAB (Food Sensitivity Assay)** \$160 fee for service or \$595.00 cash price
- ZRT LABS (Hormonal test)** 1 tube test \$200.00 cash price; 4 tube test \$300.00 cash price
- ABI** \$165.00
- ECHOS** \$350.00
- ANSAR** \$200.00

The fact that your insurance 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.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.

Option 1. YES. I want to receive these items or services. I understand that I may be asked to pay a portion or an upfront fee, but I also want my insurance billed for an official decision on payment. Please submit my claim to my insurance for these items or services. I may have to pay the bill while my insurance is making its decision. If my insurance does pay, any payment made will be refunded back to me, less co-pays, co-insurance or deductibles. I understand I can appeal my insurance's decision.

Option 2. YES. I want to receive these items or services. Do not bill my insurance. I will pay the **CASH PRICE** for this service. I cannot appeal if insurance is not billed.

Option 3. NO. I have decided not to receive these items or services.

Signature of Patient

Date ____/____/____

Signature of patient or person acting on patient's behalf

Date ____/____/____

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Good Health Through Nutrition, Exercise and Stress Management.