Neurology Center of Fairfax
3020 Hamaker Court, Suite 400
Fairfax VA 22031
703-876-0800

PLEASE GO TO THE RESTROOM PRIOR TO THIS PROCEDURE.

AUTONOMIC TEST

PATIENT INSTRUCTIONS

Autonomic Testing is a painless and highly sensitive test. During the test you will need to sit, stand and lie down. EKG leads are applied to your chest wall and information about your heart rate and rhythm is transmitted to a computer to measure your Heart Rate variability (RR-variation), a key indicator of cardiovascular disease in diabetics and other conditions. This Autonomic Test accurately measures Heart Rate Variability using (3) accepted standard tests approved by the American Diabetes Association.

- **Paced Breathing (RR-Variation)**
- **Valsalva**
- **Posture**

Paced Breathing Test requires the patient to match his/her breathing (inhaling and exhaling) to a burst of inclining and declining tones for 5 minutes.

Valsalva Testing requires the patient to exhale into a manometer for 20 seconds. This is repeated twice.

Posture Testing requires the patient to stand up for (10) seconds, lie down for (3) minutes and then stand up again for (1) minute.

The results provide quantitative assessment of heart rate variability in response to specific respiratory and posture regimens. An interpretation will be made in conjunction with all other available medical history and diagnostic test information and reported to your doctor.

Preparation For The Test

You must take a bath or shower prior to the appointment in order to remove oil from your chest area. **DO NOT** use body lotion or powder on the chest area on the day of the test. Please bring or wear a loose fitting shirt.

Test results will be discussed with you at your follow-up visit with your physician.

Please do not bring children to testing appointments.

A *$75.00* fee is charged for all appointments missed or not cancelled 24 hours in advance.

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Neurology Center of Fairfax
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Fairfax VA 22031

Advance Beneficiary Notice/Advance Beneficiary Waiver (Commercial Insurance)

Date: _____ NCF Number: _____ Patient DOB: _____

Patient Name: _____ Insurance: _____

Please be sure that you understand the commitment you are making. If you do not understand your options, ask for assistance.

It is very likely your insurance will **NOT** pay for the services described below. Your doctor believes that these testing services are in the best interest of your health.

One or more of the following services will be provided to you. These may not be covered by _____ health insurance. If they are not covered, below are the estimates for the cost of each service. You would be responsible for these costs if you have one or more of these studies performed.

95925 – Short Latency Somatosensory Evoked Potential Study – upper limbs/median	$355
95926 – Short Latency Somatosensory Evoked Potential Study – lower limbs/tibial	$349
95927 – Short Latency Somatosensory Evoked Potential Study – trunk and neck/pudendal	$365
95938 – Short Latency Somatosensory Evoked Potential Study – upper/median and lower/tibial	$704
95921 – Autonomic Test – Heart Rate	$200

The reason for the possibility of non-coverage is that it is considered to be investigational by some insurances.

If you choose to proceed with these services, please complete the agreement below, which binds you to pay for these services if your health insurance does not pay for them.

Beneficiary Agreement:
I acknowledge that I have been notified by my physician of the possibility of denial of insurance coverage for these services. I wish to proceed with the services anyway. If my insurance denies coverage for these reasons or for any reason, I agree to be personally and fully responsible for payment of these charges when billed.

Signature _____ Date _____

Witness _____

(050216)

A. Notifier: **Neurology Center of Fairfax, Ltd.**
3020 Hamaker Ct, Suite 400
Fairfax, VA 22031

C. Identification Number: _____

B. Patient Name:

Patient Date of Birth:

Advance Beneficiary Notice of Noncoverage (ABN)

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

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
95925 Short Latency Evoked Potential UL	Not a Covered Charge	$355
95926 Short Latency Evoked Potential LL	Not a Covered Charge	$349
95927 Short Latency Evoked Potential Trunk	Not a Covered Charge	$365
95938 Short Latency Evoked Potential M/T	Not a Covered Charge	$704
95921 Autonomic Test-Heart Rate	Not a Covered Charge	$200

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.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare 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.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare 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 Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: