NEUROLOGY CENTER OF FAIRFAX, LTD.

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# *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 _____