Advance Beneficiary Notice of Noncoverage (ABN)

Client Name: _____

Date of Birth: _____

Date: _____

NOTE: Although we are non-par with HSMA, Medicaid, Medicare and most insurance companies, including HMSA, do not typically pay for QEEG Brain Mapping and Neurofeedback (because they still consider these "alternative"), nor do they typically cover psychoeducational testing because it is available through the DOE. Therefore, you will be required to pay out-of-pocket, even though you or your health care provider has good reason to think you or your child requires this care.

Your required actions at this stage are as follows:

• Read this notice, so you can make an informed financial decision about your care.

• Ask us any questions that you may have after you finish reading.

• Choose an option below about whether to receive or not to receive services.

Please check only one box. We are unable to make this selection on your behalf.

□ OPTION 1. I would like to receive the services I have checked below. I understand I will be required to pay for these services upfront, however I would like to request the necessary documents from your office (a "superbill") so that I can submit claims to Medicaid, Medicare or my private insurance company. All payments made to Whole Foundation and/or Cultivate Mental Health/Hawaii Neurofeedback Institute are due at the time of service and are considered full and final. In the event I receive reimbursement from my insurance carrier, I understand they will come directly to me, therefore there will be no refunds made for out-of-pocket payments.

□ OPTION 2. I would like to receive the services I have checked below. I understand I will be required to paid for these services upfront and I *do not* require any documentation from your office (a "superbill") to submit claims to Medicaid, Medicare or my private insurance company. All payments made to Whole Foundation and/or Cultivate Mental Health/Hawaii Neurofeedback Institute at the time of service are considered full and final.

□ OPTION 3. I am declining to receive the services listed below. I understand with this choice I am not responsible for payment, and I cannot appeal to determine if Medicaid, Medicare or my private insurance company will cover services offered.

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

Fee Schedule for Culitvate Mental Health and Wellness Program/Hawaii Neurofeedback Institute: **(**please check requested services)

- _____Comprehensive Evaluation: $4,495.00
- _____Mini Evaluation: $2,495.00
- _____2 QEEG Guided Neurofeedback Session or 1 NF session + Counseling: $210.00
- _____Counseling (50 min): $175.00

Missed Appointment & Cancellation Policy: **(**please initial)

- _____Appointments must be cancelled or rescheduled 24 **hours in advance**
- _____I understand that I may be charged a fee for missed appointments

Agreement

By signing below, I acknowledge that I have read and understand the above policies regarding fees, billing, and financial responsibility. I agree to abide by these policies and accept responsibility for payment of services received.

Client/Parent/Guardian Signature: _____ **Date:** _____

Provider/Representative Signature: _____ **Date:** _____