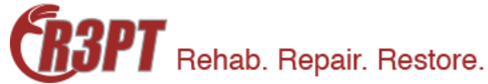

R3PT - Advanced Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care services.

PLEASE READ THIS ENTIRE NOTICE CAREFULLY

PATIENT NAME: ____________________________________

DOB: ____

The purpose of this form is to help you make an informed choice about receiving Physical Therapy treatments. During the course of your treatment, your insurance company may determine that you have reached the maximum allowable number of Physical Therapy sessions under your insurance coverage. If you choose to continue treatment that has been prescribed by your physician, you will be charged a fee not to exceed $150.00 per session for all remaining treatment sessions.

- It is your right to ask for an explanation if you don’t understand why your insurance carrier will not pay for all sessions.

Please check one of the two options below:

☐ Option 1: Yes, I want to receive physical therapy treatment. I fully understand that my insurance company has a maximum benefit. When that benefit has been met, I will be responsible for up to $150.00 per session, with payment due at the time services are rendered.

☐ Option 2: No, I am electing not to receive physical therapy treatments once my insurance benefits have reached their maximum allowable.

SIGNED: ____________________________**DATE:**__________

WITNESS: ___________________________**DATE:**__________