ADVANCE BENEFICIARY NOTICE FOR WELLNESS COVERAGE

My signature below acknowledges the following:

___ I have confirmed with my insurer that I have "Wellness" or "Preventive Health Care" coverage, and acknowledge that the charges for my examination, tests and services performed today will be submitted to my insurer as a "Wellness/Preventive Health Care" evaluation.

___ I do not have "Wellness" benefits, and acknowledge that the charges for my examination, tests and services performed today will be submitted to my insurer as a diagnostic evaluation.

___ I do not know whether I have "Wellness" benefits, and acknowledge that the charges for my examination today will first be submitted to my insurer as a "Wellness?Preventive Health Care" evaluation.

I further understand that it is I.M.A. policy not to re-submit claims once they have been filed as either Wellness or Diagnostic examinations, and accept financial responsibility for payment-in-full of any charges not covered by my insurer.

I have been informed that there is a $20 monthly re-billing fee for any outstanding balance 60 or more days past due, and acknowledge that I am financially responsible for any assessed penalties related to delayed payment.

______________________________________ _______/_______/_________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE SIGNED

______________________________________ ______________________________

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY RELATIONSHIP TO PATIENT