



**Laurel Medical Associates Disclosure Form/Advance Beneficiary Notice (ABN)**

1. Medicare or your insurance may not cover all of your medical care services. Medicare or your insurance only pays for covered services when certain rules are met. The fact that services are not covered does not mean that they are not indicated or needed. These services will be your responsibility. Home visit prices range from \$100-250. Toenail cutting costs \$50-75. EKG costs less than \$100. There are additional fees for weekend, emergency, and evening hours.
2. You or your designee is responsible for all fees that are not covered by your insurance. This includes late fees and attorney fees.
3. Certain documents will be completed without any additional fees. Some forms will require a fee and you will be informed if there are any prices before completion of specific paperwork. There are also additional fees for delivery of specific supplies to your home or facility.
4. If a patient is not able to consent to their care or sign this document, their representative will be required to sign this document and be responsible for the services provided.
5. Home care visits are unique services performed in a patient's home or facility. All attempts will be made to perform services as soon as possible. At times if you cannot be seen in an expeditious manner other recommendations including emergency evaluation will be made depending upon your medical problem.
6. All patients who may participate in a mail order program with their insurance are encouraged to provide the office with self-addressed envelopes to assist with mailing of any forms. Depending on the form, certain handling fees may apply. A minimum fee of \$7.00 will apply for shipping and handling.
7. The office understands that at times items will need to be mailed to you at times postage and handling fees will apply.
8. A fee will be applied for all returned checks and stop payment returned checks.

\_\_\_\_\_  
Patient Name (Authorized Representative) Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (Authorized Representative) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Laurel Medical Associates

\_\_\_\_\_  
Date