

ADVANCE BENEFICIARY NOTICE FORM

Pope Paul VI Institute Physicians, PC
6901 Mercy Road Omaha, NE 68106

BEHAVIORAL HEALTH SERVICES

I, (Patient's Name) _____ on (Date) _____

understand that the following will apply and be enforced as long as I am a patient of

Dr. Kelly Morrow, Ph.D. at the Pope Paul VI Institute:

Most insurance companies have determined that the following procedures or services provided for you by this office may be deemed "not medically necessary/non-covered" services. Therefore, you are responsible for payment for the following services. These are the ranges of prices and are dependent on the level or complexity of service provided.

- **Telephone Consult \$60.00 - \$150.00** _____ **Patient's Initials**
This will not be billed to your Insurance Company and prepayment is required.
- **Visit Cancellation or No Show Fee \$35.00** _____ **Patient's Initials**
(less than 24 hour notification)
- **Psychological Testing \$350.00** _____ **Patient's Initials**
Some Insurance Companies will not pay for Psychological Testing.
If testing is ordered, we will verify eligibility for this testing.
If not eligible, prepayment for testing is required.
- **Legal Issues (Estimate Available)** _____ **Patient's Initials**

These services have been explained to me and I agree to be personally and fully responsible for payment. I understand that prepayment of these services may be requested. I understand that the PPVI staff will work with me to help me know when these are applicable.

Patient's Signature _____ Date _____

Guarantor's Signature (if patient is minor) _____ Date _____

Witness's Signature _____ Date _____