

**ADVANCE BENEFICIARY NOTICE**

**Date:**

**Patient Name:**

**Insurance:**

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**We expect that your Insurance Company will not pay for service (s) that your physician feels is necessary to manage your healthcare. The test(s) are as followed:**

- **T-Wave Alternans**
- **Bio-Z**
- **EECP**

**The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it.**

**The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you have to pay for them yourself.**

**Estimated Cost: \$\_\_\_\_\_**

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.**

**OPTION 1. YES. I want to receive that test. I understand that my insurance will not pay and I agree to be personally and fully responsible for payment. That is, I will pay out of pocket for this test.**

**OPTION 2. NO. I have decided not to receive this test. I will not receive these services.**

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**SIGNATURE OF PATIENT**

**DATE**