Advance Patient Notice (APN)

Patient Name:	Patient Date of Birth:	Patient Health Plan Name/ID:
Patient Phone:	Patient Address:	Patient Email:
Ordering Provider Name:	Ordering Provider NPI:	Ordering Provider Phone:
Rendering Provider Name:	Rendering Provider NPI:	Rendering Provider Phone:

Your health care provider has decided to provide services that your health plan provider may determine is not medically necessary, experimental, investigational, unproven, or a non-covered service. The fact your health plan does not pay for these services does not mean you cannot receive the service. To assist you in making an informed decision regarding your health care, if you decide to receive these services, please sign this form to indicate you have had a discussion with your health care provider about these services and your health care options and you are agreeing to services that may not be covered by your health plan. By signing this form, if you obtain these services, you are agreeing to be financially responsible for any and all charges related to the services outlined in this document if your health plans determine the services are not covered.

Item/Service/Procedure Code(s):	
Description of Service(s):	
Anticipated Date(s) of Service:	

Estimated Cost: $ _____

Shodair Children's Hospital allows payment plans and has financial assistance available for those who qualify. Please reach out to the billing office once you receive your first statement if you would like to discuss these options.

☐ Yes, I want to receive these items or services. I understand that these items or services may not be paid by my health plan and that I will be financially responsible for any and all charges related to the services outlined in this document. I understand I will be contacted if any additional services need to be performed.

_____ _____

Signature of Patient or Authorized Representative Date