Acknowledgment of Financial Responsibility/ Advanced Beneficiary Notice

Note: You need to make a choice about receiving these health care items. Please read this entire notice carefully.

To:_____

Re: Durable Medical Equipment & supplies

We expect that your health care benefits insurer or administrator, _____ _____, may not pay the full retail price for the upgraded items that are listed below. The total estimated cost for these items is: $_____.

Items purchased and upgrade reason(s):

I have been informed that my insurer or administrator may not cover the items listed above in full. Pretty In Pink Boutique has also informed me about alternative items, if any, that may be covered by my insurer. If insurance does pay, Pretty In Pink Boutique will refund to me any payments I made to them that are due to me. If my insurer denies payment, I agree to be personally and fully responsible for the payment. I understand that this cost difference may not appear as "patient responsibility" on my insurer's Explanation of Benefits (EOB).

By signing this form, I certify that I elect to receive these items and pay the amounts disclosed to me by Pretty In Pink Boutique.

_____
Signature of Patient/Responsible Person

_____
Date

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