Patient Name: **Date of Birth**

TYPE Of SERVICE PROVIDED		
Zoom or Telephone Integrative / Functional Medical Consultation(s)		

Advance Beneficiary Notice of Non-coverage (ABN)

- Read this notice, so you can make an informed decision about your care.
- I agree with the statement printed in the box.

I desire the Integrative / Functional Medical Service(s) listed above. I understand that this type of Integrative / Functional Medicine Service(s) is a non-covered medical insurance service. As such, I understand that I am personally responsible for all Payments in full. Fee Schedule: New Patient: $300 Established Patient: Prorated on a base of $100 per 20 minutes

Signature:	Date: