Golden Gate Pediatrics

A Medical Corporation

Patient's Name: _____

Date of Birth: _____

Advance Beneficiary Notice (ABN)

Note: You will need to make a choice about receiving this health care item/service.

Our office offers the inactivated Typhoid Vaccine for patients two years or older who are travelling to parts of the world where typhoid is common. Your health insurance company may not pay for the item and service described above. The plan that you have chosen as your health insurer does not necessarily cover all of your health care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for this service, does not mean that you should not receive it.

Description of Item/Service: **Inactivated Typhoid Vaccine**	
Vaccine Cost per dose: **$ 175.00**	Administration Fee: **$65.00**

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. By signing below, you agree to take financial responsibility for the cost of the item/service. As a courtesy, we will submit a claim for the item/service to your insurance company.

Responsible Party signature: _____

Responsible Party Name (print): _____

Date: _____

San Francisco: 1 Daniel Burnham Court, #330C San Francisco, CA 94109 ╬ Telephone (415)668-0888 ╬ Facsimile (415)752-5391
Mill Valley: 61 Camino Alto #107, Mill Valley, CA 94941 ╬ Telephone (415)388-6303 ╬ Facsimile (415)388-7136
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