Chad D. Aschtgen, ND, FABNO
Erica J. Joseph, ND, L.Ac, FABNO
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Thank you for choosing our clinic for your naturopathic care. Please read the following informed consent, acknowledgement of privacy practices, financial policies, assignment of benefits and fees thoroughly prior to your first visit. It is important that you understand these policies. Please ask your physician or a staff member should you have any questions or have need for clarification.

## 1. Informed Consent

I, _____, acknowledge that my physician is responsible for directing my care and may advise me of the need for services such as diagnostic testing, medical or surgical treatments, nutrition, dietary supplements, exercise, lifestyle and other counseling, manual therapies, acupuncture and any other necessary health related service. By signing below, I hereby authorize and give my consent to all such services instructed by my physician(s), her/his assistants or designees. I acknowledge that no expressed or implied guarantees have or will be made to me by my physician, any affiliate practitioner or staff regarding cure or improvement of my condition. I also realize that my practitioner(s) cannot anticipate and explain every possible risk or complication, and I wish to rely on the practitioner to exercise judgment during any of the above procedures and in recommending any other treatments for my condition(s).

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*initials*

## 2. Notice of Privacy Practices Acknowledgement

I acknowledge that I have received and read the "*Notice of Privacy Practices*" and authorize Seattle Integrative Oncology (SIO) to use and disclose information, including patient record sharing with my other providers at connected care locations, about me and my health to diagnose and treat me, obtain payment for care and for SIO business operations. Additionally, I grant SIO the authority to acess my medication history automatically from pharmacy benefit managers (PMBs). I wish to have the following restrictions to the use or disclosure of my health information:

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*initials*

## 3. SIO Teaching Facilities

I understand that the physicians at Seattle Integrative Oncology (Chad D Aschtgen, ND, PLLC) from time to time offer preceptorships to medical students and resident physicians who may observe or participate in the care provided and I have the right to decline their presence during my visit, procedure or treatment at any time. I understand that medical students, residents and office staff are subject to, and will abide by, the above referenced privacy policies.

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*initials*

## 4. Payment Policy

**All fees are due at the time of service.** However, if you are covered by a health insurance plan that we are presently contracted with and you have naturopathic care benefits, we will bill your insurance carrier directly. **Please note that if you are responsible for a co-payment, this will be due at the time of service and payable by cash, check, debit or credit card.** If you do not have health insurance or have a plan that has not contracted with our physicians, a 20% prompt payment discount is available on office charges when payment is received at the time of service.

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*initials*

## 5. Insurance Policy

Please remember that while naturopathic medical services are covered by many insurance carriers, each company, their various plans and individual policy benefits can vary greatly. Although our staff may assist you as a courtesy, ***it is your responsibility to be aware of the benefits, limitations, payment requirements and specific exclusions of your health insurance coverage***. For each covered service and/or procedure provided, we will only charge your insurance the "allowable amount", as defined uniquely by each individual carrier, and will not bill you for the difference (excluding co-payments, applicable co-insurance and any deductible amount as defined by your individual health plan).

Some of the testing, procedures and therapeutic products recommended by our physicians may not be covered by your insurance plan. Additionally, your insurance company may refuse coverage or pay only a portion or percentage of fees. ***You will be responsible for any and all allowable fees not covered by your insurance plan.***

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*initials*

## 6. Assignment of Benefits

I authorize *Seattle Integrative Oncology* (SIO) to receive direct payments for any benefits to which I am entitled to, and may otherwise be payable to me, under my health insurance plan. Further, I authorize SIO physicians and/or their office staff to furnish my health insurance company all medical and administrative information that may be requested in order for payment of benefits. This signed authorization is intended to apply to all insurance submissions whether manual or electronic. Finally, I accept full responsibility for all charges not covered by my insurance plan, including those that may be deemed 'not medically necessary'.

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*initials*

## 7. Non-covered services

Non-covered services are those visits, procedures, consultation and/or diagnostic codes, telephone consults, electronic portal communications, *et cetera*, that are not covered by your health insurance policy. **We will bill you directly for any denied charges or non-covered services.** These may include, but are not exclusive to, the following:

- Naturopathic care services; **including extended visit fees** (new visits >75 minutes, return visits ≥50 minutes)
- Counseling, wellness visits and non-curative/palliative treatments
- Functional lab tests; often considered 'investigational' or 'experimental'
- Missed appointments
- Non face-to-face time; including coordination of care and extensive medical record review

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*initials*

## 8. Appointment Change, Cancellation and No-Show Policy

We request at least one business day (24-hour) notice for changing or cancellation of any appointment. **A 'no-show' or cancellation without a minimum 24-hour notice may result in a $50 cancellation fee.** Exceptions include medical emergency, severe/inclement weather, or other urgent situations deemed acceptable by the individual practitioner.

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*initials*

## 9. Fees

- *Telephone Consults* - $200 (up to 30 minutes)
  **We do not routinely provide telephone services**, however a practitioner may occasionally be available outside of a regularly scheduled appointment to discuss your health concerns. A simple question that can be addressed briefly, such as medication dose clarification or identifying a high-quality dietary supplement brand, will not generate a fee.
- *Nutritional Supplements*
  Dietary supplements recommended by our team are typically not covered by health insurance; although you may be eligible to apply funds from your *Health Savings Account* (HSA). You may purchase high quality vitamin, mineral, protein and herbal supplements from numerous sources and we will provide multiple recommendations for in-store, on-line or local physician office resources as a convenience.
- *Email / Portal Policy*
  To provide you the best care possible, **we will not provide healthcare services via email correspondence**. However, you may submit clarifying questions, scheduling requests and other administrative concerns via your Athena Health portal account at https://***www.11614.portal.athenahealth.com***. Other electronic services may incur a $75 fee (CPT: 99444).
- *Delinquent Account* - $20 service charge, plus 1.5% monthly penalty of the remaining total balance
  Outstanding, unpaid accounts may be charged a service fee of $20 at 90 days from date of initial charges to cover cost of ongoing administrative service and repeated invoicing. Further, a 1.5% monthly penalty fee may be applied to all outstanding balances older than 90 days.

## Authorization for Treatment and Financial Responsibility Statement

**I understand that it is my responsibility to understand my health insurance policy and its benefits. I acknowledge that I have read, fully understand, accept and agree to be legally bound by the terms and conditions contained herein.**

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| _____ | _____ |
| *Print Patient's Name* | *Patient's Signature* *Date* |
| _____ | _____ |
| *Print Name of Patient Representative/Guardian* | *Signature of Patient Representative/Guardian* *Date* |