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Thank you for choosing our clinic for your naturopathic care. Please read the following items thoroughly prior to your first visit. It is important that you understand these policies. Please ask a staff member or your physician should you have any questions or need for clarification.

1. Informed Consent

I, _____ , acknowledge that my physician(s) will be directing my care at Seattle Integrative Oncology PLLC (SIO) 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. (This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. **You have the right to discuss any questions or concerns regarding treatment recommendations with your physician. You also have the right to decline recommended treatments and/or discontinue services at any time**.) 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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2. Notice of Privacy Practices Acknowledgement

I acknowledge that I have received and read the "*Notice of Privacy Practices*" and authorize Seattle Integrative Oncology PLLC (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 access my medication history automatically from pharmacy benefit managers (PBMs). I wish to have the following restrictions to the use or disclosure of my health information:

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3. SIO Teaching Facilities

I understand that the physicians at Seattle Integrative Oncology PLLC (SIO) offer preceptorships to medical students and training to 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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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 submit a claim to 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. This prompt payment or time of service discount will not be extended in cases of an insurance claim being submitted and subsequently denied by your insurance plan for any reason.

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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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6. Assignment of Benefits

I authorize Seattle Integrative Oncology PLLC (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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7. Non-covered services

Non-covered services are those visits, procedures, consultation and/or diagnostic codes, telehealth 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**; a new office or telemedicine visit lasting up to 60 minutes (99205) and follow up visits up to 40 minutes (99215) face-to-face. Please note, it is anticipated that your physician care team spends an additional 15 minutes preparing for your visit by reviewing relevant paperwork and outside medical records, documenting the visit, and completing a visit summary, as well as communicating details of care to your other providers when necessary.
- **Prolonged Service Fee**; any visit with total duration beyond the above noted times will incur an extended visit fee. Such prolonged office services (99417) will be billed in 15-minute increments as detailed in the current official CPT code book.
- **Non Face-to-Face Time**; including coordination of care and extensive medical record review, generally not on the day of your visit and typically more than 30 minutes total time (99358).
- **Electronic Communication Services**; based on the complexity of issue and time necessary to evaluate and manage (99421).
- **Functional Lab Tests**; which are often considered not-medically necessary, 'investigational' or 'experimental'.
- **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/FSA). You may purchase high quality vitamin, mineral, herbal and other dietary supplements from numerous sources, and we will provide multiple recommendations for in-store, on-line or local physician office resources as a convenience.

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8. Appointment Change, Cancellation and No-Show Policy

We require at least two business days (48-hour) notice for changing or cancellation of any appointment. ***A 'no-show' or cancellation without a minimum 48-hour notice will result in a $75 cancellation fee.*** Exceptions include medical emergency, severe/inclement weather, or other urgent situations deemed acceptable by the individual practitioner.

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9. Telephone, Email, & Patient Portal Policies

- **Telephone Consults**; we do not routinely provide telephone services (99441-3). Rather, please consult our office to schedule a telemedicine visit with your practitioner.
- **Email Communications**; to provide you the best care possible, we do not routinely provide email communications with patients. Please submit all electronic communications via AthenaHealth patient portal (see below).
- **Patient Portal**; patients and their family/ caregivers can submit concerns and questions, whether related to your healthcare or administrative matters via the **AthenaHealth patient portal** at https://11614.portal.athenahealth.com. Neither brief, clarifying health related questions, nor administrative or billing concerns will generate a service fee.

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10. Delinquent Accounts

Patient accounts are delinquent when there is an unpaid balance greater than $200 for more than 90 days. Unless a monthly payment plan has been established in writing, delinquent patient accounts are referred to an outside agent for collections. Furthermore, an additional $25 service fee may be charged and an added 1.5% monthly penalty fee on the remaining total balance is applied until the account becomes current. Any account with a patient balance due of greater than $200 will require full payment or a credit card funded payment plan of a minimum of $50/ month in order to reschedule your next appointment.

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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.

****We reserve the right to update these office policies from time to time and will publish them on the website.****

Print Patient's Name | *Patient's Signature* | *Date*

Print Name of Patient Representative/Guardian | *Signature of Patient Representative/Guardian* | *Date*