

PATIENT RELEASE OF INFORMATION AUTHORIZATION

By signing this Release of Information and Authorization Form, I authorize the release of any medical information necessary to my insurance company and the payment of benefits to Cascade Integrative Medicine, PLLC, the parent company of Center for SIBO Testing, for services received. I also authorize the release of information to the staff of Cascade Integrative Medicine and to the provider that ordered my test.

PATIENT INSURANCE AND TEST PAYMENT GUIDELINES

1. I understand that Cascade Integrative Medicine is contracted with the following insurance carriers: Blue Cross Blue Shield, Premera, Regence, Lifewise, Asuris, First Choice Health, Kaiser Permanente (through First Choice Health), Cigna, Molina (Marketplace and Medicaid), Coordinated Care (excluding Apple Health Medicaid). Unless otherwise specified, Cascade Integrative Medicine is not contracted with Medicare, Medicaid, Tricare, Aetna, or United Healthcare. I agree to elect "Self-Pay", and I understand that I am responsible for \$225 for the breath test, if Cascade Integrative Medicine is not contracted with my insurance carrier.
2. I agree to enclose a check in the amount of \$225 payable to Cascade Integrative Medicine if electing "Self-Pay". I understand that my test results cannot be released until payment, in full, is received if I have chosen to be "Self-Pay".
3. I understand that if my insurance carrier does not cover all charges, I will remit payment to Cascade Integrative Medicine for the remaining balance based on the rules of my insurance plan.
4. I understand that my insurance carrier may remit payment for this test directly to me. I acknowledge that if this happens, I will forward it directly to Cascade Integrative Medicine, or I will provide payment to Cascade Integrative Medicine for the check amount that was sent to me by my insurance carrier.
5. I understand that, at my discretion, Cascade Integrative Medicine will arrange a payment plan with me that I am comfortable with so that I don't have to pay the entire balance in one installment. I understand that there is a 5% interest charge on all payment plans and that the balance must be paid in full within six months.
6. I agree to call Cascade Integrative Medicine directly at (425) 395-7544 with any questions about insurance coverage, payment for the test, or the Explanation of Benefits (EOB) statements I receive from my insurance carrier.

Patient (Please Print) _____ Date of Birth _____
First MI Last

Signature of Patient or Responsible Party _____ Date _____