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 I am responsible for a one-time, non-refundable payment, in advance, of $35 for shipping, handling, and procurement of my breath test kit, and I understand that this charge is not covered by my insurance and is separate from, and in addition to, the laboratory charge of $225 detailed below.
2. I understand that Cascade Integrative Medicine is contracted with the following insurance carriers: Blue Cross Blue Shield, Premera, Regence, Lifewise, Asuris, Bridgespan, Providence Health, First Choice Health, Kaiser Permanente (through First Choice Health), and Cigna. I understand that if my insurance carrier is not listed above, I agree to elect "Self-Pay", and I understand that I am responsible for $225 for the laboratory charges associated with my breath test. Furthermore, I understand that Kaiser Permanente only covers breath testing if it is ordered by a gastroenterologist. If my test is ordered by a provider who is not a gastroenterologist, I understand that my charges will not be billed to insurance, and I agree to elect "Self-Pay".
3. I understand that my test results cannot be released until payment, in full, is received if I have chosen to be "Self-Pay". I agree to enclose a check in the amount of $225 payable to Cascade Integrative Medicine or to provide my credit card information if electing "Self-Pay".
4. 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.
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 _____

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CENTER FOR SIBO TESTING