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 $42 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 acknowledge and understand the following insurance billing and coverage considerations:
   a) I understand that the laboratory charge of $225 will be billed to my insurance if my insurance carrier is one of the following: Blue Cross Blue Shield, Regence, Asuris, Bridgespan, Regence Group Administrators, Healthcare Management Administrators, Cigna, Kaiser Permanente, Molina Medicaid, and First Choice Health. I acknowledge that Kaiser Permanente only covers SIBO testing when it is ordered by a gastroenterologist; if Kaiser Permanente is my carrier and my test is ordered by a provider who is not a gastroenterologist, I understand my charges will not be billed to insurance and I agree to elect "Self-Pay."
   b) If my carrier is not listed above, I understand that either (1) The Center for SIBO Testing is out-of-network with my insurance plan, or (2) my insurance carrier does not cover SIBO/IMO testing. In either case, I agree to elect "Self-Pay" and understand that I am responsible for the $225 laboratory charge.
   c) Network participation is not a guarantee of coverage, and I agree to contact my insurance carrier to verify my coverage beforehand.
3. I understand that my test results cannot be released until payment, in full, is received if I have chosen to be "Self-Pay". By agreeing to be "Self-Pay", I agree to one of the following payment methods:
   a) I agree to enclose a check with my samples in the amount of $225 payable to Cascade Integrative Medicine;
   b) I authorize the secure storage of my credit or debit card information and payment upon arrival of my samples to the laboratory; or
   c) I agree to prompt payment of the electronic invoice I receive by secure text or email after my samples have been analyzed, but before my results are released.
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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