Institute of Complementary Medicine
1600 E Jefferson Street, Suite 603
Seattle, WA 98122-5649

Financial consent - ICM

APPOINTMENT CONTRACT

I agree to be here on time for all of my scheduled appointments. If I am unable to keep my appointment, I will give the Institute of Complementary Medicine (ICM) at least 1 business days (24 hours)
advance notice. If I fail to show for my appointment or am more than 15 minutes late without contacting the clinic, I understand that I will be charged a $50 appointment non-compliance fee for a 30 minute appointment and a $100 non-compliance fee for a 60 minute appointment. Payment for this fee will be my responsibility and will not be filed with any third party. I
agree to pay this fee in full before rescheduling any type of appointment at ICM.
I understand that appointment times are given as estimated times that patients will be seen by the doctor. I understand the length of an office visit is based on the needs of each individual patient in the clinic and that there may be minimal or extended delays.

PLEASE NOTE

The first visit with our office will take 1 to 1.5 hours. If you do not have this much time, you may want to reschedule your appointment.

Signature : _____

FINANCIAL AGREEMENT

I hereby acknowledge that
my health insurance policy is an arrangement between the Health Plan and myself.

As a courtesy, ICM does verify your coverage and co-pay responsibilities with
your insurance. I understand it will be my responsibility to understand my insurance policy and its benefits before arriving to my appointment. I also understand that certain services and tests may be ordered by the doctors located at ICM which may not be covered by my insurance. I agree to be financially responsible for these services and tests.

Annual exams and dual licensed providers

If medical treatment is requested during an annual physical exam, I understand that my provider is allowed to bill the insurance carrier for those services separately from the annual exam charge. I also understand that if my provider is credentialed as both an acupuncturist and naturopath and both modalities are used during the visit my provider will also bill both visits separately.

Important questions to ask yourself before your appointment :

Do I have naturopathic benefits?

If not you will be responsible for paying at the time of your visit. A 20% time of service

payment discount is offered to patients paying out of pocket.

Do I have a co pay? What percentage of my visit is covered by my insurance and do I have a deductible?

Co-pays are due at the time of service. Deductible and co-insurance fees are also a patient responsibility.

How many office, acupuncture, and/or preventive visits am I allowed each year?

If coverage is denied due to overage amount of visits, the patient will be responsible for the balance.

Do I need a referral?

Please make sure referrals are in before the time of your appointment.

Signature : _____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep record of the health care service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.You may see your record or get more information about it by contacting the office manager.

Our Notice of Privacy describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices from the Institute of Complementary Medicine.

Patient or legally authorized individual signature : _____

Patient name if signed on behalf of the patient _____

Relationship * ☐ Patient, ☐ legal guardian ☐ personal representative

Today's Date _____

This form will be retained in your medical record.