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

Financial consent 2019

Financial Policy Agreement

At ICM we want to create and maintain good relationships with our patients. Please read the following policies carefully BEFORE agreeing. Any payment disputes will be referred back to this agreement. If you have any questions, please ask a staff member. Please check each question to show that you understand and agree.

Insurance (In-Network and Out-of-Network)

As a courtesy, ICM does verify your insurance is active and your 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. Providers at ICM are contracted with many insurance companies; not all providers are contracted with the same insurance companies. It is my responsibility to check with my insurance directly to verify that my provider is covered by my specific plan. I am responsible for all copays, coinsurance and deductibles per my insurance plan. It is my responsibility to make sure a prior authorization is in place prior to my appointment if needed. *

☐ I understand and agree to the above
☐ Others ___________________________

If my provider is out-of-network with my insurance, I will be responsible for payment at the time of service. I understand that I will be given a 20% cash discount and ICM will courtesy bill my insurance for me. My insurance will then reimburse me directly depending on my plan benefits. *

☐ I understand and agree to the above

Copayments are due at the time of service *

☐ I understand and agree to the above

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

☐ I understand and agree to the above

acupuncturist and naturopath and both modalities are used during the visit my provider will also bill both visits separately. *

☐ Others ____________________________

Appointment Agreement

I agree to be in the office 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 day advance notice, weekends and holidays do not count as a business day. This notice will be given by either calling the front desk or messaging through the portal (not direct email). (Example: Must cancel by 3:00pm on Friday for a 3:00pm appointment on Monday). 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. *

☐ I understand and agree to the above

Payment processes

For scheduled appointments, prior balances must be paid prior to the visit *

☐ I understand and agree to the above

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Patient balances are billed every four weeks, you can pay your balance at any time through our convenient patient portal. If we do not receive payment before our next billing cycle, we will charge your card on file. If there is a problem with your bill you must contest within that timeframe. However, refunds will be given when appropriate. *

☐ I understand and agree to the above

If we cannot process your card on file, we will contact you via the patient portal or by phone for the bill to be paid within 10 days. If the bill is not paid within 10 days you may be put into the collection process. After you receive your final notice, you will have 10 days from that notice to pay any outstanding amounts. After these 10 days your account may be referred to a third-party collection service and a 25% fee will be added to the existing amount. *

I have read and understand this financial policy and agree to comply with the terms. I claim responsibility for any payment that becomes due as outlined above.

PATIENT SIGNATURE : ______________________________

☐ I understand and agree to the above

ICM policy requires a valid credit card to be kept on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable due to your deductible and coinsurance requirements. Your credit card information is kept safe and confidential in a cloud-based portal installed and guaranteed to be secure by BlueFin, a world leader in payment processing technology. We do not have access to your full credit card number, only the last four numbers. Payments to your card are processed only after the claim has been filed and processed by your insurer and the insurance portion of the claim has first been paid and posted to the account. You will be notified by both your insurance via your Explanation of Benefits and an invoice from us as to what you owe prior to your card being charged. You may also pay your bill online through the patient portal to prevent a charge to your card two weeks after

billing. Please remember that ICM only charges what your insurance company leaves to you. If you disagree with a charge, please first contact your insurance company and review your explanation of benefits. *

I, the undersigned, authorize and request ICM to charge my credit card on file, for balances due for services rendered that my insurance company identifies as my financial responsibility or denies due to non-coverage. This authorization relates to all payments not covered by my insurance company for services provided to me by any healthcare provider at ICM. This authorization will remain in effect until I cancel this authorization. To cancel, I understand that I must give a 60 day notification to ICM in writing and the account must be in good standing.

PATIENT SIGNATURE : ______________________________

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.

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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.