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 ordering provider.

PATIENT INSURANCE AND TEST PAYMENT GUIDELINES:

1. I understand that Cascade Integrative Medicine contracts with most commercial insurance carriers, excluding Medicare and Medicaid, and will always submit claims to my insurance carrier on my behalf. If Medicare or Medicaid is my only source of insurance, I understand that I am responsible for $225 for the breath test.
2. I understand that if my insurance carrier does not cover all charges, I will remit payment to Cascade Integrative Medicine, the parent company of Center for SIBO Testing, for the remaining balance.
3. 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.
4. 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.
5. 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