CONSENTS & POLICIES

NO SHOW & CANCELLATION POLICY

WE STRIVE TO PROVIDE APPOINTMENTS THAT FIT YOUR SCHEDULE. YOUR RESERVED TIME IS SET ASIDE SPECIFICALLY FOR YOU. LATE CANCELLATIONS NOT ONLY IMPACT YOUR CARE BUT ALSO PREVENT OTHERS FROM USING THAT TIME.

- ❖ LATE CANCELLATIONS - THOSE MADE WITH LESS THAN 24 HOURS NOTICE, MAY RESULT IN A $50.00 FEE.
- ❖ NO-SHOWS - PRIMARY CARE: $175.00
  MASSAGE / PHYSICAL THERAPY $85.00

PLEASE ARRIVE ON TIME AND READY TO BEGIN YOUR SCHEDULED APPOINTMENT

- ❖ LATE ARRIVALS OF 10 MINUTES OR MORE MAY BE CONSIDERED A LATE CANCEL, REQUIRING TO RESCHEDULE YOUR APPOINTMENT AND SUBJECT TO THE $50.00 LATE CANCEL FEE.

CANCEL AND NO-SHOW FEES MAY REQUIRE PAYMENT PRIOR TO SCHEDULING FUTURE APPOINTMENTS. PLEASE NOTE THAT YOUR INSURANCE CARRIER IS NOT RESPONSIBLE FOR THESE CHARGES.

PATIENT INITIALS: _____

CONSENT FOR SURESCRIPTS

I CONSENT TO THE CENTER FOR FUNCTIONAL HEALTH/THE PACIFIC CLINIC AND ITS STAFF OR CONTRACTORS OBTAINING MEDICAL INFORMATION VIA SURESCRIPTS, AN THIRD PARTY COMPANY FACILITATING E-PRESCRIPTIONS AND THE EXCHANGE OF MEDICAL RECORDS BETWEEN HEALTHCARE ORGANIZATIONS AND PHARMACIES.

PATIENT INITIALS: _____

NOTICE OF PRIVACY PRACTICES

I UNDERSTAND THE CENTER FOR FUNCTIONAL HEALTH WILL COMPLY WITH HIPAA WHEN USING OR DISCLOSING MY HEALTH INFORMATION. I MAY REQUEST RESTRICTIONS OR A FULL COPY OF THE NOTICE OF PRIVACY PRACTICES AT ANY TIME.

I AUTHORIZE THE CENTER FOR FUNCTIONAL HEALTH TO SHARE MY PROTECTED HEALTH INFORMATION WITH THE PACIFIC CLINIC TEAM AS NEEDED FOR MY TREATMENT, OR PARTICIPATION IN REGENERATIVE TRAINING, OR THE MEDICAL WEIGHT LOSS PROGRAMS.

PATIENT INITIALS: _____

NOTICE OF NON-PARTICIPATION

I UNDERSTAND CENTER FOR FUNCTIONAL HEALTH IS NOT A PARTICIPATING PROVIDER FOR MEDICAID STATE INSURANCE. I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES AND BALANCES THAT CANNOT OR WILL NOT BE BILLED TO MY MEDICAID PLAN.

I UNDERSTAND CENTER FOR FUNCTIONAL HEALTH DOES NOT BILL OUT-OF-NETWORK CLAIMS FOR NON-CREDENTIALED INSURANCE PLANS. I AM RESPONSIBLE FOR PAYING THE PROMPT-PAY RATE AT THE TIME OF SERVICE AND FOR SUBMITTING CLAIMS TO MY INSURANCE FOR REIMBURSEMENT.

PATIENT INITIALS: _____

FINANCIAL POLICY & PATIENT AUTHORIZATION

I UNDERSTAND THAT PRICES AND POLICIES ARE SUBJECT TO CHANGE. WHILE THE CENTER FOR FUNCTIONAL HEALTH REMAINS COMMITTED TO TRANSPARENCY, IT IS MY RESPONSIBILITY TO STAY INFORMED ABOUT THE LATEST UPDATES. THE CLINIC'S WEBSITE AND THE BULLETIN BOARD IN THE OFFICE ARE EXCELLENT RESOURCES FOR KEEPING UP-TO-DATE WITH ANY CHANGES IN PRICING AND POLICIES.

PATIENT INITIALS: _____

I ASSIGN MEDICAL BENEFITS AND PAYMENTS TO THE CENTER FOR FUNCTIONAL HEALTH AND AUTHORIZE THEM TO PROVIDE AND RECEIVE NECESSARY INFORMATION TO BILL INSURANCE/THIRD PARTIES AND RECEIVE DIRECT PAYMENTS. I AUTHORIZE PAYMENTS OF ALL MEDICAL BENEFITS DIRECTLY TO THE CENTER FOR FUNCTIONAL HEALTH FOR SERVICES PROVIDED. I AM RESPONSIBLE FOR UNDERSTANDING MY INSURANCE PLAN'S BENEFITS AND LIMITATIONS. CO-PAYMENTS AND PATIENT BALANCES ARE DUE AT THE TIME OF SERVICE.

- A FEE OF UP TO $30.00 MAY BE APPLIED IF THE CO-PAY IS NOT PAID AT THE TIME OF SERVICE. THE FEE COULD BE EQUAL TO OR DOUBLE THE AMOUNT OF THE CO-PAY, BUT WILL NOT EXCEED $30.00. PATIENTS ARE RESPONSIBLE FOR PAYING ALL APPLICABLE CO-PAYS AT THE TIME OF THEIR VISIT TO AVOID THIS ADDITIONAL CHARGE.

ANY CHARGES NOT COVERED BY INSURANCE ARE MY RESPONSIBILITY, INCLUDING OFFICE VISITS, SUPPLIES, DME, SUPPLEMENTS, PRESCRIPTIONS, AND LABS.

- BALANCES UNPAID FOR 90 DAYS ARE SUBJECT TO UP TO A 9% SERVICE FEE, IN ACCORDANCE WITH WASHINGTON STATE REGULATIONS.
- UNPAID BALANCES OVER 120 DAYS MAY BE REFERRED TO COLLECTIONS. IN THE EVENT OF LEGAL ACTION, THE PATIENT WILL BE RESPONSIBLE FOR ATTORNEY'S FEES AND COURT COSTS INCURRED IN THE COLLECTION OF THE OUTSTANDING BALANCE.

SOME CASH-BASED SERVICES MUST BE PREPAID AT THE TIME OF BOOKING, WHILE OTHERS REQUIRE THE PATIENT TO HAVE A VALID CREDIT CARD ON FILE. IF A PATIENT CANCELS LESS THAN 24 HOURS IN ADVANCE OR NO-SHOW, THE FULL COST OF THE SERVICE WILL BE CHARGED. REFUNDS OR RESCHEDULING ARE AVAILABLE FOR CANCELLATIONS MADE WITHIN THE ALLOWED TIMEFRAME.

I CONSENT TO TREATMENT BY THE CENTER FOR FUNCTIONAL HEALTH/THE PACIFIC CLINIC AND UNDERSTAND THAT COMPLICATIONS MAY ARISE. I WILL DISCUSS ANY CONCERNS WITH THE PROVIDER PRIOR TO TREATMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE CENTER FOR FUNCTIONAL HEALTH FOR SERVICES RENDERED.

PATIENTS NAME: _____ DATE: _____

PATIENT/GUARANTOR SIGNATURE: _____

(BY SIGNING BELOW, THE PATIENT ACKNOWLEDGES THAT THEY HAVE READ, UNDERSTOOD,

AND INITIALED ALL OF THE POLICIES OUTLINED ABOVE.)