Kimberly Iller, ND, LAc Functional Medicine Northwest

8010 15th Ave NW, Suite D; Seattle, WA 98117 Office: (206) 268-0397 FAX: 206-518-9225

Summary Notice of Privacy Practices

We are required by federal law to provide a Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and our obligations under federal and state privacy laws.

Uses And Disclosures

We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- To provide information about your health condition to others who may treat you;
- To provide information about the treatment that we provided in order to obtain payment from your health plan;
- To report a communicable disease, domestic violence or criminal activity; or
- To comply with a court order requiring the disclosure of your medical record.

YOUR RIGHTS

While the records that we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance you have the right to access and copy the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of each disclosure that we have made of your health information. All of these rights are subject to some exceptions that are described fully in the Notice.

OUR OBLIGATIONS

We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may amend the Notice from time to time. All amendments apply retroactively. If you have any questions or require additional information, please contact: Kim Iller, ND, LAc 206-719-4043

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 206-719- 4043 or by requesting one at this office.

Printed name of client: _____

Signature of client or representative: _____Date: _____

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FINANCIAL AGREEMENT AND CONSENT FOR DISCLOSURE

By signing below I agree:

1. That Functional Medicine Northwest (FMNW) may share any financial information I provide to facilitate payment.

2. To pay FMNW for balances remaining after insurance benefits are paid, unless prohibited by law or contract. This includes paying copayments at time of service. If deductibles are known, FMNW may collect at time of service.

3. To notify FMNW of changes to my insurance coverage and/or address.

4. That FMNW may impose reasonable interest, late charges, costs and/or other reasonable attorney fees should my account become delinquent. Any lawsuit for collection of my account may be brought in King County, Washington. I understand that should this account be referred to collections I will be responsible for the unpaid balance, collection fees, and other associated costs.

5. To notify FMNW if I am not able to pay my balance within 30 days of receipt. Patient statements are mailed every 30 days from date of service if a balance is due. Payment is normally due on receipt.

6. To receive information related to treatment, payment or health care operations, including receiving message calls and/or text messages at any number that I have provided, or if not current, to any number I am reasonably found to be associated with.

7. That FMNW may, at its discretion, disclose to appropriate parties any medical records or information from my records for treatment, payment and health care operations.

I understand that:

1. The FMNW Providers do not bill all insurance plans, nor may they be considered "participating providers" for all insurances or specific plans within certain insurances. While FMNW may submit an insurance claim as a courtesy for me, that claim is my responsibility.

2. **Neither Medicare, Medicaid nor L & I covers services or supplies provided in this office.**

3. All consultations may be required to be paid at time of service unless prior insurance authorization has been approved.

4. The exact co-insurance or co-payment responsibility will depend upon the actual services provided and the coverage my insurance may have. At my request, FMNW staff may be able to provide me with an estimate of the billed charges for services I am likely to receive.

5. FMNW reserves the right to impose a missed appointment charge of $50 if I fail to cancel an appointment within 48 hours business Hours Monday-Friday. I understand that if my appointment is Monday at 2 pm that I will cancel by the previous Thursday before 2 pm. I am to provide either phone or portal acknowledgement for cancellation. Missed appointments are not billed to insurance. I have been

informed of the $50.00 fee (per RCW 62A.3-515) on all checks returned from my bank for nonsufficient funds.

Statement to Permit Payment of Insurance Benefits to Provider:

I request payment authorized insurance benefits for any services furnished to me by FMNW. I authorize any holder of medical and other information about me to release to my insurance provider any information needed to determine these benefits for related services.

Signature (Patient or Person Authorized)	**Date**
If signed by person other than patient , indicate relationship to patient:	**Office Use:**