

# **Financial Responsibility Policy**

Thank you for choosing **Anacortes Integrative Medicine, Inc.** We are committed to transparent pricing and clear financial expectations.

This document outlines the financial policies governing payment for services and membership fees. This policy is separate from and in addition to the Membership Medical Care Agreement.

## **1. Membership & Self-Pay Practice**

Anacortes Integrative Medicine, Inc. operates on a direct-pay / self-pay model.

The Practice:

- Does not bill private insurance
- Does not bill Medicare
- Does not bill Medicaid
- Does not bill third-party payers

Membership fees and service fees are paid directly by the patient.

We may provide a receipt upon request, but we do not guarantee reimbursement from any insurer.

## **2. Payment Timing**

### **Membership Fees**

- Billed monthly in advance in accordance with the Membership Medical Care Agreement  
Automatically charged to the payment method on file

Payment is due:

- At the time of booking (if required), or
- At or before the time services are rendered

Accepted forms of payment may include:

- Credit or debit card
- ACH
- HSA/FSA cards
- Other approved methods

A valid payment method may be required to remain on file.

### **3. Payment Authorization & Card on File**

By signing this policy, you authorize Anacortes Integrative Medicine, Inc. to charge your payment method on file for:

- Monthly membership fees
- Visit fees not included in membership
- Late cancellations
- No-shows
- Outstanding balances
- Approved supplements or products

You agree to:

- Maintain accurate and current payment information
- Ensure sufficient funds are available at the time of billing
- Provide updated payment information within five (5) business days if a charge is declined

Failure to maintain valid payment may result in:

- Suspension of scheduling privileges
- Suspension or termination of membership benefits

You will receive notice of charges when feasible.

### **4. Cancellations & Missed Appointments**

- Appointments must be cancelled at least 24 hours in advance.
- Late cancellations or no-shows may be charged in full.
- Arrivals more than 15 minutes late may be considered a missed appointment.
- One emergency waiver per calendar year may be granted at the clinic's discretion.

## **5. Laboratory, Imaging & Third-Party Services**

You are financially responsible for:

- Laboratory testing
- Imaging
- Supplements
- Medications
- Referrals
- Specialty services
- Procedures not included in membership

These services may be billed separately by third-party vendors.

## **6. Refund Policy**

Membership fees compensate the Practice for:

- Access and availability
- Care planning
- Reserved clinical capacity

Membership fees are:

- Non-refundable once billed
- Not prorated for partial months

Additional financial terms:

- Fees for services rendered are non-refundable
- Prepaid services are non-refundable unless otherwise stated in writing
- Administrative fees may apply to certain refunds or transfers

## **7. Outstanding Balances & Chargebacks**

Balances not paid within 30 days may:

- Result in suspension of scheduling privileges
- Result in suspension or termination of membership
- Be referred to collections, if necessary

You are responsible for reasonable collection-related costs, including:

- Administrative fees

- Attorney's fees, as permitted under Washington law

You agree:

- Not to initiate a chargeback without first contacting the Practice to attempt resolution
- That improper chargebacks may result in additional administrative and processing fees

## **8. Medicare & Government Programs**

If you are enrolled in Medicare, you may be required to sign a separate Medicare Private Contract acknowledgment.

## **9. Agreement**

By signing below, you acknowledge:

- You accept financial responsibility for services provided.
- You authorize recurring charges for membership fees.
- You understand additional services may incur separate charges.
- You understand insurance will not be billed by this practice.

Patient Name:

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Patient Signature:

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Date: \_\_\_\_\_