Grow Integrative Health
1655 SW Highland Ave. Suite 5
Redmond, OR - 97756

NP: TOS Agreement

Good Faith Estimate

To allow for transparency for our patient's, we have outlined medical costs estimates for Time-of-Service Patients. This estimate will help you understand costs associated with seeing our providers in advance.

Please note: Time-of-Service rates are only applicable at the time services are rendered and must be paid at the time services are rendered. PATIENT SIGNATURE *

Services listed here include office visits, other services such as blood draws or urine analysis, and any other fees that might apply.

Please note, our costs are different from the lab costs. Labs will charge you for running the analysis of samples taken in office. PATIENT SIGNATURE *

Patient Name and Date of Birth: *

Your Insurance Company: *

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Provider: Dr. Camella Potter, ND

This provider is only in-network with the following insurance companies:

>Aetna

>EMBS

>First Choice

>Moda

>Pacific Source, not including Pacific Source OHP

>Providence, not including Providence OHP

Total cost estimate of what you may be asked to pay:

>Review your detailed estimate from below

>Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your health plan and your provider options.

Please note: if our provider is out of network, balance billing may be applied to your invoice, which you, the patient, are responsible for. PATIENT SIGNATURE *

Estimated services, including CPT codes, with Time-of-Service rates:

CPT Code Description Estimated amount

99203 New Patient office visit- 1 hour $ 280.00

99204 New Patient office visit-extended $ 336.00

99205 New Patient office visits $ 406.00

99213 Established office visit- 30-40 minutes $ 168.00

99214 Established office visit-extended 45 minutes-1 hour $ 231.00

99215 Established office visit- more than 1 hour $ 301.00

US Biotek Food Sensitivity Testing $ 179.00

36415 Venipuncture $ 30.00

3420 Injection, B12 $ 40.00

90806 LENS single visit $ 125.00

LENS Package- 5 visits $ 500.00

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The above amount is an estimated cost for Time-of-Service Patients in lieu of billing insurance. Providers offer a 30% discount on billable services for Time-of-Service Patients, which is reflected in the above amounts.
By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.
With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured.
I also understand that:
>I’m giving up some consumer billing protections under federal law.
>I may get a bill for the full charge for these items and services or have to pay out-of-network cost-sharing under my health plan.
>This is a written notice stating the provider is not in my health plan’s network and will be charged the estimated cost by the provider.
>I got notice either on paper or electronically, consistent with my choice.
>I fully and completely understand that some or all amounts I pay might not count toward my health plan’s deductible or out-of-pocket limits.
>I understand that this payment for services provided within the allowed time for the visit and any requests outside of the visit will be billed separately and could range from $50-100 (these include electronic communication, forms to fill out, communication via phone).
>I can end this agreement by notifying the provider in writing before getting services.
Important: You don’t have to sign this form. But if you don’t sign, this provider might not treat you or will bill insurance, leaving full amounts not including discounted prices your, the patient’s, responsibility.

PATIENT SIGNATURE *