Southeastern Center for Infectious Diseases, P. A.

OFFICE INFORMATION & POLICIES

First, we would like to welcome you to our office. We are empathetic to your illness and want to make this experience as pleasant as possible for you. The patient-physician and patient-nurse relationship is unique. It implies mutual trust, openness, and responsibility. Your well-being is extremely important to us. We will always strive to maintain your confidence in us. Please note that no other person other than office staff is allowed in patient area without patients consent.

OFFICE HOURS

The office is open Monday through Friday from 8:00 am to 5:00 pm. The infusion center is open from 8:00 am to 5:00 pm daily including Saturdays and Sundays and holidays. Office appointments are scheduled Monday through Thursday from 8:30 am to 3:30 pm.

APPOINTMENTS

We make a sincere attempt to adhere to the appointment schedule as closely as possible. We appreciate the value of your time and dislike long waiting periods. We will provide a friendly reminder call 24-48 hours prior to your scheduled appointment in our office. We appreciate your courteousness in providing our office with at least 24 hours notice if you are unable to keep your scheduled appointment. **If you fail to contact our office to reschedule and/or cancel your appointment at least 24 hours in advance OR if you fail to show up for a scheduled appointment, you will be charged a $25.00 fee. If you call in sick the day of your appointment and can provide us with a physician's note, you may be exempt from the payment.** All patients are seen by scheduled appointments only.

RELEASE OF INFORMATION

We treat all medical information pertaining to each patient seen in our office to be personal and confidential. It is our strict policy not to release your records, in part or in full, at any time unless we have written permission from you. This policy is enforced regardless of the circumstances. Therefore, we require a signed **"Release of Information"** form by every patient before we will copy any information contained within your medical chart to any third party, including but not limited to, other physicians, insurance companies, and/or an attorney. Remember, when you sign a release for an insurance company, you give them access to all information contained in our medical records unless you restrict the information to be released. This request may also pertain to records regarding drug & alcohol treatment, mental health records, communicable disease records, including HIV/AIDS.

INSURANCE & PAYMENTS

Patients who have insurance are responsible for paying any co-payments, co-insurance, deductibles that have not yet been met, and non-covered services at the time services are rendered by the staff at Southeastern Center for Infectious Diseases, P.A. It is your responsibility to make sure the requirements of your insurance plan have been met both prior to and subsequent to your visit with our office.

You should remember that your policy is a contract between you and your insurance company and that you (the patient) have the final responsibility for payment of your medical bills. As a courtesy, we will submit claims to your insurance company and/or provide you with the forms and information necessary for you to arrange reimbursement for your medical expenses associated with your treatment by us. Payments can be made by cash, check, debit or credit card (MasterCard, Visa, Discover, and American Express). There is a $25.00 bank charge for all returned checks.

If you do not follow your plan's requirements or you fail to provide our office with accurate up-to-date information regarding your insurance coverage, you may be financially responsible for all or part of the bill. Also, Southeastern Center for Infectious Diseases, P.A. may not participate in your healthcare plan and services may not be covered. We will make every effort to accurately inform you of your responsibility in terms of payment prior to your visit with Dr. Philbert Ford and/or our Advanced Registered Nurse Practitioner, when you have provided our office with accurate and complete information regarding your insurance.

By signing below, you allow our facility to submit your information to your insurance carrier and that you acknowledge receipt and review of this policy and the HIPPA Privacy Act in its entirety.

Patient Printed Name: _____

Patient/Responsible Party Signature: _____ Date: _____

You are encouraged to call us with any questions or concerns you may have. For the best results, unless it is an emergency, please contact us during normal office hours when your medical record is readily accessible.
We look forward to caring for you!