Infectious Disease Professionals Financial Policy

* For the convenience of our patients, we participate with Medicare, Medicaid, and most major insurance companies. We will file with your insurance; however, any applicable co-payments are due at the time of service. The patient is responsible for any non-covered charges incurred.
* If your insurance requires a referral from your primary care physician, you must provide the information that we may bill charges to your insurance carrier.
* In the event you are not covered by insurance, payment is due when services are rendered unless other arrangements have been made in advance. Self-pay price is $150.00 for initial visits, and $75.00 for follow-up visits: Please note this does not include any lab work or radiologic procedures.
* Patients please be advised that if your insurance does not cover Lyme Disease treatment, you will be responsible for all non-covered charges.
* A $35.00 fee will be charged to patients for returned checks.
* A $50.00 fee will be charged for all No-Show appointments.
* By signing this, you agree with the policies stated above and the medical information release below.

To our patients: All physician offices must now confirm patients' demographic information and verify patients' identity at each visit under the Federal Government's Identity Theft Red Flags and Address Discrepancies Rule. A photograph will be taken of you in the exam room. You must provide us with a photo ID, such as a driver's license that shows your current address. The photo ID will be used at all future visits to confirm your identity and to identify any reg flags for both financial and medical identity theft. Infectious Disease Professionals, LLC is committed to protecting our patients' information and prohibits illegal misrepresentation. Thank you for cooperating with us to keep you and your information safe!

I Understand/agree that Infectious Disease Professionals may leave medical/ financial information by the following methods: home telephone, home answering machine, cell phone, work telephone, and work voicemail. I consent to Infectious Disease Professionals (the Practice) using or disclosing my protected health information (PHI) for the purpose of providing treatment to me or to carry out the treatment activities provided by another health care provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my PHI in order for assessment and reviewing the competence of health care professionals, The following people are also authorized to receive a copy of my PHI.

Patient Signature: _____ Date: _____