SOUTHWEST INFECTIOUS DISEASE ASSOCIATES, LTD

1051 Essington Road, Suite 210, Joliet, Illinois 60435
(815) 726-1818
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Office Policy

Welcome! We look forward to seeing you for your appointment. Enclosed you will find information forms that we would like you to complete prior to your first visit. Please bring them with you to your appointment. Your clear understanding of our office policy is important.

Your First Visit

Please bring your insurance card and photo ID on your first visit so that it may be copied for your file. It is a good idea to bring your card and photo ID to every appointment. If your insurance ever changes, it is especially important to let us know and bring your new card.

Contracted HMO and PPO Plans

Your co-pay is due at the time of service. The balance of your bill will be billed to your insurance. If your HMO requires a referral form from your primary care physician; it is your responsibility to have this by the day of your visit. If an appropriate referral is not provided, we cannot bill your insurance and you will be fully responsible for the bill at the time of service.

Medicare

Our physicians are Medicare Providers and we do accept assignment on covered services. All Medicare patient are responsible for their 20% co-insurance and annual deductible.

Missed Appointments

If you are unable to keep your appointment please notify our office at least 24 hours in advance. You can leave a message with our answering service. Failure to provide 24 hours notice will result in a no-show charge and will be collected to the extent permitted by law. The no-show fee is $50.00.

Scheduling

Patients are not always called in order of arrival due to the fact that appointments may be with any one of our providers, nurse, or the clinical staff. We make every effort for you to be seen at your scheduled time; however, unforeseen emergencies or complicated or unusually ill patients may cause us to run behind. Please be understanding in that someday your emergency or illness may affect others.

_____ _____

(signature of Patient or Legal Representative) (Date)