***Infectious Diseases Associates, P.C.***

729 Grove Avenue

Southampton, PA 18966

215-355-9634

Fax 215-357-7540

**Conditions of Treatment**

The physicians and staff of Infectious Diseases Associates, P.C. are committed to your health and well-being.

As our patient, we hope you to agree to the following:

1. To notify Infectious Diseases Associates, P.C., if there are any changes in my health, employment, insurance, or address and/or telephone number.
2. To pay my co-pay at the time of my visit.
3. To pay any co-insurances and/or deductibles within thirty (30) days of my receipt of a bill.
4. I understand that if I fail to show up for an appointment or fail to cancel said appointment with less than 24 hours notice, that I will be billed $50.00.
5. I understand if I am more than 15 minutes late for my appointment, I may be asked to reschedule.
6. I will show up for all appointments, on the time schedule recommended by my physician. However, I understand that I must show up for at least one appointment every twelve months, if I am on medications for a chronic condition.
7. I understand if I have three (3) no shows, I will be terminated from the practice.
8. I understand that I must be seen in order to have my medications refilled.
9. To take the medications prescribed for me.
10. I understand that the physician – patient relationship is based on mutual respect and trust. I agree that proper office behavior and decorum are essential when communicating with both the IDA staff and physicians.
11. I understand any act or threat of physical violence, harassment, intimidation, cursing, foul or inappropriate language or other threatening disruptive behavior are grounds for termination of the physician – patient relationship.
12. To notify Infectious Diseases Associates, P.C., if there are any changes in my health, employment, insurance, or address and/or telephone number or any other issue that may prevent me from staying in care.

This contract has been reviewed with me.

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Printed Name

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Signature Date

01/08/19