Stephen A Schulman MD
2214 Emery St. Ste 210
Denton Texas 76201
Phone: (940) 382-9448
Fax: (940) 382-7509

Notice of Privacy Practices

Acknowledgement of Review

I have reviewed the Notice of Privacy Practices for Stephen A. Schulman, MD. This notice of privacy practices explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Print name of Patient (or Legal Guardian)

_____
Signature of Patient (or Legal Guardian)

Date: _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All Patients must complete our Parent Information Slip and show proof of insurance before being seen by the doctor.

***FULL PAYMENT OF CO-PAY IS DUE AT THE TIME OF SERIVCE**
***WE ACCEPT CASH, CHECKS OR VISA, MASTERCARD OR DISCOVER**

REGARDING INSURANCE:

We may accept assignment of insurance for your office visit (verify your insurance acceptance with the receptionist). The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you give us your current insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance has not paid your account in full within 90 days the balance will automatically be transferred to the responsibility of the guarantor. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance policy provisions.
Regarding insurance plans where we are a participating provider: all co-pays are due at the time of service. For plans with a deductible, the guarantor is responsible for the day's charges in full at the time of service.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of those rates.

MINOR PATIENTS:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment or co-pay. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

I have read and understand the Financial Policy.

Signature: _____ Date: _____