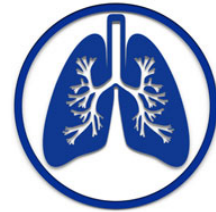


Peter N. Schochet, MD
Hauw S. Lie, MD
Board Certified Pediatric Pulmonologists



Financial Responsibility Policy

Financial responsibility is determined first, by the insured, and second by the adult signing the patient in at the time of the appointment. Please note that both, if different, will be submitted to collection agencies should the financial obligations of appointments not be met in a timely manner.

Charges will be accumulated and routinely filed with your insurance company during the course of treatment by Peter N. Schochet, MD. Charges not covered by your insurance, patient co-pays, deductibles, and co-insurance will be your responsibility and are due at the time of service.

If your insurance company requires a referral from your primary care physician, *you* will need to contact your PCP for the referral. Treatment provided by this office without the required referral will serve as your consent for treatments not covered by insurance, and will be payable at the time of service.

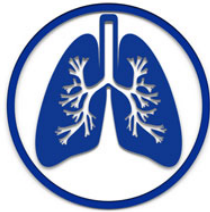
Divorce and Separated Parents

- It is not this office's legal responsibility or desire to arbitrate or enforce legal divorce judgments. Our responsibility is to provide quality child and adolescent health care.
- If in the divorce settlement, only 1 (one) parent is assigned responsibility for the medical expenses of the child, and the "non-assigned" parent presents with the child seeking medical attention, it is the presenting parent's responsibility to provide payment for those medical services as rendered, and then in turn forward the medical statement to the "assigned" parent for reimbursement.
- It is NOT our office's responsibility to collect payment from the absent parent, even though that parent has been assigned responsibility of the child's medical expenses. This is a matter that should be resolved by the parents outside this office.

Notice to Parents of Financial Interest

You are informed by this Notice that Dr. Schochet holds a financial interest in the **Texas Health Center for Diagnostics and Surgery**, which includes the **Pediatric Sleep Institute**. You have the option, at your discretion, to use an alternate health care facility.

Pediatric Pulmonologists
Peter N. Schochet, MD & Hauw S. Lie, MD
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972-981-3251 • 972-981-3254 FAX • www.pedilung.com



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Please check one of the following:

_____ I certify that I have no insurance and will be solely responsible for payment in full.

_____ I certify that the insurance reported to Peter N. Schochet, MD is a complete and current listing. I understand the office will not extend credit on, or submit a claim for any insurance not reported at the time of service.

I understand that any claim not paid by my insurance within 60 days from the date filed may become my responsibility and is payable upon billing.

Authorization to Release Medical Information

I authorize Peter N. Schochet, MD to release any medical information requested by physicians or insurance companies regarding treatment at this facility.

Insurance Assignment

I hereby authorize payment to be made directly to Peter N. Schochet, MD by my insurance company for any charges for services covered by the terms of my policy. I agree to cooperate, aid, and assist the facility in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I have read and understand the above information and hereby authorize Peter N. Schochet, MD to prescribe and provide treatment for my child.

Patient Name (Please print): _____

Parent or guardian name (for minor patient): _____

Parent or guardian signature (for minor patient): _____

Social Security # of the above: _____ - _____ - _____ Date: _____

See statement above regarding financial responsibility.