Emily A. Sheveland, D.O.

Board Certified – Family Medicine

972-548-1717
972-548-9190 Fax
5236 W. University Drive
Suite 3200
McKinney, TX 75071

2026

ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICIES AND PROCEDURES

Our primary mission is to provide you with quality, cost effective medical care. Together we are trying to adapt to the changing way that healthcare is financed and delivered. With the government mandated conversion to electronic health records as well as "cost saving measures" implemented by government and private health insurers, we are discovering many requirements both on the part of the government and insurance industry that now necessitate these fees which are not covered by third party payers. Again, we value you as a patient and our first priority is to provide you and your family with the best possible care. Dr. Sheveland welcomes any open and honest discussion regarding this changing nature of healthcare.

I am aware of the following policies and procedures of the office of Emily A. Sheveland, D.O.:

_____ Initials — Missed appointment and cancellation fees for less than 24-hour notice for any appointments ($50)

_____ Initials — Arriving late or after your scheduled appointment time will result in needing to reschedule your appointment.

_____ Initials — Form completion fee ($25) if requesting to be completed outside an appointment.

_____ Initials — For HMO Policies – referrals or changing of referrals that require phone authorization to complete. ($25)

_____ Initials — Re-filing fee ($25) due to *my* (the patient's) failure to update insurance info resulting in delayed payment.

_____ Initials — I understand that the online patient portal is the means for refill and lab requests as well as non-urgent and non-emergent communications.

_____ Initials — I understand that I will be contacted regarding ALL test results ordered through the office of Emily Sheveland, D.O. ***I will NEVER ASSUME NO NEWS IS GOOD NEWS***. If I still have questions about my results, I will schedule an appointment to discuss the results with Dr. Sheveland.

I acknowledge that I reviewed a copy of the 2025 Office Policies and Procedures for the office of Emily Sheveland, D.O. (and obtained a personal copy at my discretion) and agree to the terms as outlined therein.

_____ Signature

_____ Date

_____ Name Printed

_____ Preferred Contact Phone Number