TRAN, M.D., F.A.C.S., P.A.
FINANCIAL AND INSURANCE POLICIES

Dear Patient:

We would like to take this moment to welcome you to our office. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial and insurance policies.

1. Payments are due at the time of service; this includes your co-pays, co-insurance, deductibles and so on. If for any reason you do not have your financial portion we have to reschedule your appointment.

2. We accept personnel checks up to $100.00. Anything over $100.00 will be accepted in the form of cash, cashier check or money order payable to Dr. Anthony Tran. We do accept Visa, MasterCard, Discover Card and American Express cards.

3. We offer different financing companies who are dedicated to helping you with your medical and/or cosmetic expenses.

4. There will be a minimum of $20.00 charge for the filling out of all paperwork. Some examples are FMLA and Short Term Disability.

5. It is the patient's responsibility to get referrals if needed and notify us of any insurance changes. You need to also alert us if you have any changes to your contact information.

6. We need you to present your insurance card at every appointment.

7. If you write a check and it is returned NSF there will be a $35.00 NSF fee added to the original amount of the check. It is this office's policy to alert you once we receive a NSF check. We give you ten business days to correct the situation or we will turn the matter over to the District Attorney.

8. Not all insurance plans cover all services. In the event your insurance plan determine a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Thank you for coming to our practice. Please tell us if you have any questions or concerns.

I have read and understand the practice's financial and insurance policies and I agree to be bound by its terms. I also agree and understand that such terms may be amended by the practice from time to time.

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Signature of patient (or responsible party, if minor) **Date**

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Please print the name of the patient