Diplomat American Board of Plastic Surgery
Cosmetic & Reconstructive Plastic Surgery
Hand & Microsurgery

PATIENTS ARE RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS POLICY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

PATIENT INFORMATION **REFERRED BY** _____

NAME:(LAST)_____(FIRST)_____(MI)_____

HOME ADDRESS _____ CITY_____ZIP_____

HOME PHONE: (____)_____ WORK PHONE: (_____)_____

CELL PHONE: (____)_____ EMAIL:_____

DATE OF BIRTH:_____ AGE:_____SS#:_____

EMPLOYER & ADDRESS:_____

OCCUPATION: (IF STUDENT, NAME OF SCHOOL) _____

SINGLE: _____ MARRIED: _____ DIVORCED: _____ SEPARATED: _____ WIDOWED: _____

RESPONSIBLE PARTY/INSURED MEMBER (POLICY HOLDER)

NAME(LAST):_____(FIRST)_____(MI)____

HOME PHONE: (____) _____ WORK PHONE:(____)_____

DATE OF BIRTH: ____/____/____ AGE: _____ SS#_____

EMPLOYER: _____ OCCUPATION: _____

RECORD RELEASE

_____(Initial) WE ARE REQUIRED TO GET WRITTEN AND SIGNED AUTHORIZATION FROM THE PATIENT, GUARDIAN, AND OR COURT APPOINTED CARETAKER PRIOR TO RELEASING ANY INFORMATION OR ANY PART OF YOUR RECORD THAT WE HAVE ON FILE.

LEAVING MESSAGES

_____(Initial) AS THE PATIENT, GUARDIAN AND OR COURT APPOINTED CARETAKER; YOU GIVE US AUTHORIZATION TO LEAVE EITHER (DETAILED OR LIMITED MESSAGES) ON YOUR (CELL PHONE AND/OR ANSWERING MACHINE).

NOTIFY IN CASE OF EMERGENCY
PLEASE LIST THE NAME OF AN IMMEDIATE FAMILY MEMBER NOT LIVING IN THE SAME HOUSEHOLD.

NAME: _____ RELATIONSHIP: _____

ADDRESS:_____ CITY:_____ZIP:_____

HOME PHONE: (____)_____WORK: (____)_____

CELL PHONE: (____)_____ BEEPER: (____)_____

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PLEASE READ THE FOLLOWING CAREFULLY

The information that I have given is correct to the best of my knowledge. I agree, whether I sign as an agent or patient, that in consideration of the services rendered to the patient, guarantee payment to Anthony T.B. Tran, M.D., F.A.C.S., P.A. Payment in full is required on a timely basis regardless of whether any third-party payment is pending. Should the account be referred to a collection agency, I shall pay all costs of collection. Should the account be referred to an attorney for collection, I shall pay all expenses of collection, to include reasonable attorney fees, whether or not suit is filed. All delinquent accounts bear interest at the legal rate.

As a courtesy to our patients we often file insurance claims, but insurance filing, follow-up and fee payment is the responsibility of the patient. If payment is not received from your insurance company within 45 days from the date of service, payment will be expected from you (except Medicare, Medicaid and Workman's Compensation claims). Meeting filing deadlines for your insurance plans are your responsibility.

PLEASE READ YOUR INSURANCE CONTRACT

Our usual, reasonable, and customary fee is based on data from the Physician Fee Reference. Our fees, however, may differ from the fee schedule of your insurance company. YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE.

I authorize the release of any and all medical information necessary to process claims on my behalf. I also AUTHORIZE all medical and health care PAYMENTS whatsoever DIRECTLY TO Anthony T.B. Tran, M.D., F.A.C.S., P.A. Authorization of direct payment from your insurance company to Dr. Anthony Tran DOES NOT relieve you of your responsibility to file and follow the claim, to meet deadlines, or to pay for services in full.

Again, you will be responsible for paying all attorneys fees, court fees, filing fees, collection fees, interest at the maximum lawful rate, etc. should such action become necessary to collect fees for services rendered by this practice.

I HAVE READ THE ABOVE MENTIONED STATEMENTS AND CONDITIONS. I FULLY UNDERSTAND THESE STATEMENTS AND CONDITIONS AND AGREE TO THEM.

PATIENT SIGNATURE:_____ **DATE**:_____

PATIENT NAME: _____

PARENT/GUADIAN NAME (if patient is minor under 18 years old):_____