TRAN PHYSICIAN GROUP

Date:____________________ Physician:____________________________

Name:____ Sex: ______________________

Address: ____

City: _________________________________ State: ________________ Zip: _______________

Phone #:____ ☐ Cell ☐ Home

Date of Birth:__________________________ Age:_ Marital Status:_________________________________

Social Security #:____________________________ Work Status: ☐ Employed ☐ Retired ☐ Student

Email Address: ____(for patient portal)

INSURANCE INFORMATION [Name on Insurance Card(s)**]**

Primary - Insurance company: ____

Insured's Name:____ **Insured's Date of Birth:** ______________

Relationship: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**____________________________________

Insured's Phone Number:___________________________________ ☐ **Cell** ☐ **Home**

Secondary - Insurance company: ____

Insured's Name:____ **Insured's Date of Birth:** ______________

Relationship: ☐ **Spouse** ☐ **Parent** ☐ **Other**____

Insured's Phone Number:___________________________________ ☐ **Cell** ☐ **Home**

PHARMACY

Local Pharmacy:____________________________ **Phone**:____

Location:____

Mail Order Pharmacy:____

Emergency Notification Outside of Home

Name:____ Relation: _______________________________

Employer:____ Cell Phone #: ___________________________

Revised 12/01/19

TRAN PHYSICIAN GROUP
Financial Policy

Chart #:_____________

We want to thank you for choosing Tran Physician Group for your medical care. We have developed this financial policy to clarify our billing practices and to avoid any confusion in the future.

For your convenience, we accept payment by cash, check, VISA, MasterCard, Discover, or debit card.

We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit.

All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud.

Medicare Patients: All our physicians, physician's assistants, and nurse practitioners are Medicare providers, and we will submit your bill to Medicare for you. However, you are responsible for payment of your Medicare deductible each year. If you have secondary insurance, we will submit your claim to your secondary insurance as a courtesy to you, if you provide us with accurate information. If we do not receive payment from your secondary payor within 60 days after the Medicare payment has been received, it will be your responsibility to make payment at that time. For patients without secondary insurance, you will be required to pay 100% of your coinsurance at the time the service is rendered.
Patients with Managed Care/PPO Plans: You will be asked to pay any deductible or copay due per your plan prior to the service being rendered. It will not be waived if the physician has rendered the service.

Patients with No Insurance: You will be asked to pay for each visit at the time of service.

Broken appointments: Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24-hour notice of cancellation to avoid a cancellation fee.

Form completion: All forms requiring medical review and physician signature, including, but not limited to, FMLA, disability, etc. are subject to an administrative fee of $25.00. These charges are not covered by insurance and must be paid before completion of the form.

Lastly, it is the patients' responsibility to notify the front desk of any changes in insurance coverage before the service is rendered. Any charges denied because of termination of coverage when we have not been informed, or because of a pre-existing condition, will be billed directly to the patient upon receipt of denial from the insurance company.

Nonpayment: If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this is to occur; you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, your physician will treat you on an emergency basis only.

I have read and understand the payment policy and agree to abide by its guidelines.

_______________________________________ _____________________

Signature of patient or responsible party **Date**

TRAN PHYSICIAN GROUP
General Consent for Care and Consent for Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________________________
Signature of Patient or Personal Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Personal Representative	**Relationship to Patient**
______________________________	______________________________
Signature of Witness	**Date**

TRAN PHYSICIAN GROUP
Authorization for Payment and/or Release of Information to
Private or Supplemental Group Insurance

Patient Name:_________________________________ Date of Birth:______________________

Address:_________________________________ City:____________ State:_______ Zip:________

☐ Insurance_________________________________ ☐ Personal Pay

COMPLETE THE BELOW SECTION ONLY IF YOU HAVE INSURANCE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician or physicians of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described below, but not to exceed the reasonable and customary charge for those services.

X____ ________________________
Signature (insured person, parent, or legal guardian) Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby also authorize the physician or physicians to release any information acquired in the course of my examination or treatment.

X____ ________________________
Signature (insured person, parent, or legal guardian) Date

MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Tran Physician Group** for any services furnished me by that Professional Association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents for information needed to determine these benefits or the benefits payable for related services.

X____ ________________________
Signature (ONLY if you have MEDICARE) Date

TRAN PHYSICIAN GROUP
Consent for Special Disclosure of Protected Health Information

Chart #:________________

Please check **Yes** or **No** for the following:

I, (print name) ________________________________, consent to Tran Physician Group employees identifying themselves and leaving messages on my answering machine (if I have one), for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call Tran Physician Group.

☐ Yes ☐ No

I consent to Tran Physician Group employees identifying themselves and leaving a message with those who answer my home phone for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to contact Tran Physician Group

☐ Yes ☐ No

I consent to Tran Physician Group employees contacting me at work, if applicable, for the purposes of appointment confirmation, follow-up after a procedure, or to inform me that I need to call Tran Physician Group.

☐ Yes ☐ No

I consent to Tran Physician employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.

☐ Yes ☐ No

*** If yes, please designate the person(s) to whom such information may be disclosed:**

Name:____ Relationship: ___________________________

Phone number(s):____

Name:____ Relationship: ___________________________

Phone number(s):____

Name:____ Relationship: ___________________________

Phone number(s):____

Patient Signature:____ **Date:**____________________

Witness Signature:____ **Date:**____________________

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TRAN PHYSICIAN GROUP
Acknowledgement of Receipt of Notice of Privacy Practices

Chart #:_____________

I, ____, acknowledge that I have received a copy of the Notice of Privacy Practices for Tran Physician Group.

X____ ______________________________
Patient Signature Date

X____ ______________________________
Patient Legal Representative (if applicable) Date

X____ ______________________________
Print name of Legal Representative (if applicable) Relationship to Patient

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FOR OFFICE USE ONLY

Tran Physician Group made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:
(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)

____

____

____ ______________________________
Employee Name Date

____
Employee Signature

Revised 12/01/19