David D Tran, M.D.

A World Of Care In One Location

GENERAL INFORMATION:

NAME: SOCIAL SECURITY NUMBER:

DATE OF BIRTH: GENDER: ◯ MALE ◯ FEMALE

HOME PHONE # : CELL # :

ADDRESS:

CITY: STATE: ZIP CODE:

EMAIL ADDRESS: MARITAL STATUS: ◯ S ◯ M ◯ D ◯ W

RACE: ◯ WHITE ◯ BLACK ◯ ASIAN ◯ REFUSE TO REPORT

ETHNICITY: ◯ HISPANIC OR LATINO ◯ NON HISPANIC OR LATINO ◯ REFUSE TO REPORT

DOMINANT HAND: ◯ LEFT ◯ RIGHT

DRIVER'S LICENSE: STATE: DRIVER'S LICENSE NUMBER:

EMERGENCY CONTACT:

PRIMARY: NAME: PHONE NUMBER:

RELATIONSHIP TO PATIENT:

SECONDARY: NAME: PHONE NUMBER:

RELATIONSHIP TO PATIENT:

POWER OF ATTORNEY(IF APPLICABLE): NAME: PHONE NUMBER:

RELATIONSHIP TO PATIENT:

PHARMACY INFORMATION:

NAME OF PHARMACY: PHONE NUMBER:

ADDRESS/LOCATION:

985-400-LIVE (5483)

www.dtheals.com | info@dtheals.com

121 Lakeview Circle, Suite A | Covington, Louisiana 70433

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FAMILY AND FRIENDS CONSENT

DATE

PATIENT NAME

Please check ONE of the following options and SIGN

☐ I give permission for Dr. Tran's office to speak with/release my medical information in regards to medications, appointments or any other information pertaining to my medical care to the following family members and/or friends:

1. RELATIONSHIP TO PATIENT

2. RELATIONSHIP TO PATIENT

3. RELATIONSHIP TO PATIENT

SIGNATURE	WITNESS (OFFICE USE ONLY)

OR

☐ I do not wish to give permission for Dr. Tran's office to speak with/release my medical information in regards to medications, appointments or any other information pertaining to my medical care.

SIGNATURE	WITNESS (OFFICE USE ONLY)

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PATIENT FINANCIAL AGREEMENT

DATE

PATIENT NAME

I hereby authorize the aforementioned insurance company to pay benefits directly to David D. Tran, M.D. LLC as provided in the policy.

I agree to pay all fees determined to be patient responsibility, including co-pay, deductibles and co-insurance amounts at the time of visit.

If patient responsibility account balances are not paid on a timely basis, I agree to pay any additional costs which may be incurred by the office such as collection fees, etc.

I authorize David D. Tran, M.D. LLC to release information to the Patient's insurance company, as needed for said reimbursement.

In the event that I fail to meet my financial obligations (as stated above), I agree to allow the following:

COMMUNICATIONS REGARDING MY ACCOUNTS

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as:

1. Any cell, landline, or text number that I provide,
2. Any email address that I provide,
3. Auto dialer systems,
4. Voicemail messages, and other forms of communications.

DATE	SIGNATURE

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INSURANCE INFORMATION

PRIMARY INSURANCE:

MEMBER ID:

GROUP NUMBER:

POLICY HOLDER:

POLICY HOLDER DOB:

SECONDARY INSURANCE:

MEMBER ID:

GROUP NUMBER:

POLICY HOLDER:

POLICY HOLDER DOB:

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ATTENTION PATIENTS

PLEASE READ THESE POLICIES MAY EFFECT YOU

Please bring all of your medicine bottles with you to EVERY office visit.

• Failure to do so may result in the rescheduling of your appointment.

CONTROLLED SUBSTANCE PRESCRIPTIONS:

• Patients are responsible for their controlled substance medications. If the prescription/medication is lost, misplaced, stolen and/or if used up sooner than prescribed, it **WILL NOT** be replaced.

• Patient/Pharmacy may request refill 2 days before due date. This doesn't mean medication will be refilled earlier than the due date. Only 1 call is necessary.

• If you disrespectful to the physician's staff with regards to your controlled substance medications, this could be a cause for dismissal from this practice.

Office policy regarding cancellations, NO SHOW and refills:

• If you are due for an office visit and you cancel your appointment, prescription refills will be given at the time of your **RESCHEDULED** appointment.

• If you are completely out of a medication it may be possible to receive a partial refill if approved by Dr. Tran, this is only enough medication to hold you over until your rescheduled appointment. This does not include controlled substance.

• If you **NO SHOW** your appointment you will not receive your medication until your next appointment and you will have to pay the **$25.00 NO SHOW FEE. If you NO SHOW 2 appointments you will not be able to schedule an appointment until your NO SHOW FEES are paid.**

• Appointment reminders are a **courtesy**; you are responsible for your appointment date and time.

Appointment and Lab protocol:

• Due to the importance of close monitoring of the patient's conditions, failure to comply with lab work and/or office visit policies will result in non refilling of medications and/or discharge from the practice.

• All routine lab work must be done at least 3 days prior to your office visit.

DATE	PATIENT SIGNATURE

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