Southwestern Foot & Ankle Associates, P.C.
11500 Highway 121, Building 700, Ste. 710
Frisco, TX 75035
Dr. Thomas H. Tran

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward the end.

We understand that your health coverage is provided through _____.

It is your responsibility to get any referrals from your primary care doctors if you are enrolling with HMO (Health Maintenance Organization) insurance carrier before seeing the doctor, otherwise you will be responsible for the full payment at the time of service for your visit and all associated charges.

You must pay any co-payment and applicable deductible amounts at time of service.

Cash paid patients are responsible for the full payment at the time of service.

There will be a $35.00 service fee charge for a returned check.

A deposit of $100.00 is required if the patient needs surgery at a surgery center or at a hospital facility. Cancellation of the surgery by the patient will forfeit the deposit.

Copy of patient's medical records requires a $ 25.00 fees. Copy of patient's X-ray requires $ 50.00 fees. These fees must be paid BEFORE the copy is made. Please allow 7 to 10 business days for completion.

I authorize the practice to submit durable medical equipments (e.g. Ankle Foot Orthoses, Orthotics, Walking Boots, Diabetic Shoes) as medically necessary to my medical insurance.

There will be **NO REFUND** or **RETURN/EXCHANGE** on Foot Supplies, Durable Medical Equipments including the customized Ankle Foot Orthoses (AFO), Orthotics, and Dr. Comfort Shoes.

Although, benefits may be verified at the time of service, any payment collected may not reflect the full patient responsibility. Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filling your medical insurance for you, we are not responsible for any limitations or exclusions in coverage that may be included in your plan. Your insurance company may require additional information from you in order to process your claim, such as: accident or injury details, or other insurance coverage information. If your health plan denies this claim, you will then become responsible for the entire balance. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical cares. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible cares. We are please to welcome you to our practice.

Attorney's Fees and Costs of Collection: Patient shall reimburse the Doctor on demand for any court costs, attorney's fees, fees of collection agents, and related costs and expenses incurred in collection and attempting to collect any amounts due from Patient hereunder.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any service not covered by my insurance carrier.

_____

Patient/Legal Guardian Signature Date