Hung D. Tran, M.D., LLC
Diplomate American Board of Psychiatry and Neurology
Practice Limited to Psychiatry

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Out-of-network Advance Patient Notice Form

You are seeking service(s) from Hung D Tran MD, LLC. Dr. Tran is a non-preferred or an out-of-network provider for your insurance.

You have the right to receive services at a participating facility or by a participating physician or provider with your insurance company in order to obtain full benefits under your health coverage. If you have questions or would like to locate an in-network physician, provider or facility to provide the service or procedure, please contact your insurance customer service at the telephone number listed on your insurance identification card.

To be completed by the patient or patient's legal guardian:

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that Hung D Tran, MD, does not participate with my insurance discounts or write-offs.

2. I understand that I may be responsible for additional costs for all services provided by Hung D Tran, MD, as specified in my benefit contract.

3. I was given an opportunity to contact my insurance before obtaining services by Hung D Tran, MD, to confirm i) my benefits for these services, ii) to **obtain prior authorization if needed**, and to iii) obtain names of participating facilities and/or participating providers that can provide the recommended services or procedures.

4. I understand that absent special circumstances (e.g., financial hardship), the non-participating facility/provider is prohibited from waiving co-payments, deductibles, coinsurance or other member cost sharing amounts.

5. I am voluntarily choosing on behalf of myself or my child/legal guardian to obtain the services or procedures from Hung D Tran, MD.

6. I am verifying that Medicare, TriCare, or Oregon Health Plan is not the primary or secondary insurance. I agree to inform Dr. Tran immediately if there is any insurance change.

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(1) Name of Insurance

_____ _____

(2) Signature of Patient, Parent (if patient is under age 18) or Legal Guardian **(3) Date**

_____ _____

(4) Printed name of Patient, Parent (if patient is under age 18) or Legal Guardian **(5) Patient DOB**