Dat Tien Nguyen, M.D., Inc.
Colorectal, General & Weight Loss Surgery
Minimally Invasive Laparoscopic Surgery
5565 W. Las Positas Blvd. Suite 360, Pleasanton, CA 94588
Phone: 925-460-3205 or 925-460-3206 Fax: 925-460-3795

Financial Policy

Thank you for choosing Dat T. Nguyen, M.D., Inc as your provider of surgical care. Our commitment is to provide high quality service. Payment for your treatment is your obligation in helping to support this commitment. To help us obtain payment for our service, all patients are required to complete the Information Registration Form before consultation with our physician.

Without your current insurance information at the time of service, you will be treated as self-pay patient. All self-pay accounts are payable at the time of service. Co-pays are due prior to consultation with the physician. All HMO and EPO patients must have a valid referral prior to consultation with the physician. Our office accept cash, check, Visa, MasterCard.

Regarding Insurance Coverage:

Our office accepts assignment of insurance benefits for insurance companies that we are contracted with. The detail of your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract or exactly what benefits are included or excluded in your plan. Please be aware that some, and may be all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. In the event you do not have benefits for what you were seen for, the balance of payment is you responsibility. You are also responsible to provide our office valid and up-to-date insurance information. If you provide incorrect insurance information to our office and payment is denied for any reason, you will be financially responsible for all charges.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Please check appropriate box:
□ I have a PPO plan.
□ I have an HMO/ EPO plan with an authorization or a referral letter.
□ I am electing to use the PPO option of my POS plan.
□ The services have not been otherwise referred or authorized as required by my health plan.

I have carefully read the financial policy. I understand and agree to this financial policy.

Name of patient:_____

Responsible party: _____

Signature: _____Date: _____