Phillip R. Fleshner, M.D. ♦ Karen N. Zaghiyan, M.D.

8737 Beverly Blvd., Suite 101
Los Angeles, CA 90048
Ph No: (310) 289-9224 Email: crsmdsfront@gmail.com Fax No: (310) 289-8995

PLEASE PRINT the information on this form ***completely and legibly***. The following information is needed to prepare our records in adherence to governmental and legal requirements. We sincerely appreciate your cooperation in this matter.

Patient's Name: _____ **Birth Date:** _____ **Age:** _____
FIRST MIDDLE LAST MM / DD / YY

Mailing Address: _____ **Height:** _____ **Weight:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Sex:** ☐M ☐F

Billing Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
(If DIFFERENT from MAILING ADDRESS)

Home Phone: _____ **Soc Sec Number:** _____

Cell Phone: _____ **Work Phone:** _____

E-mail Address: _____ **BEST contact:** ☐Home ☐Work ☐Cell ☐Email ☐Mail

Marital Status: ☐ Single ☐Married ☐ Other: _____ **Spouse's Name:** _____

Race: ☐ White/Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other: _____

Religion: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Christian ☐ Muslim ☐ Hindu ☐ Jehovah's Witness
☐ Other: _____ ☐ Prefer NOT to answer ☐ None

REFERRED BY: _____ **Ph Num:** _____ **Relation to Patient:** _____

Primary Doctor's Name: _____ **Phone Number:** _____

Emergency Contact: _____ **Ph Num:** _____ **Relation to Patient:** _____
Preferably a person other than your spouse & NOT living with you

(*For Minors ONLY*) Name of Responsible Party: _____ **Relation to Patient:** _____

INSURANCE INFORMATION:

Leave this section blank if you provided your insurance card(s) to the front desk. We will make copies to be attached with this form.

MEDICARE Number: _____ **Is MEDICARE your PRIMARY** insurance? ☐Yes ☐No
(If YES – skip next line and provide SECONDARY insurance)

PRIMARY insurance: _____ **Subscriber ID:** _____ **Group No:** _____

SECONDARY insurance: _____ **Subscriber ID:** _____ **Group No:** _____
(IF APPLICABLE)

CONSENT FOR RELEASE OF INFORMATION & TREATMENT/ ASSIGNMENT OF BENEFITS/ PRIVACY POLICY

I hereby authorize PHILLIP R. FLESHNER, M.D./ KAREN N. ZAGHIYAN, M.D. to disclose, when requested by the above named insurance carrier, referring/primary physician(s), and/or its representatives, any and all patient-related information with respect to any illness(es), medical history, or treatment and copies of medical records. I hereby consent to medically indicated treatment(s), some of which are invasive, for the condition(s)/ symptom(s) as determined by the doctor(s) at the time of visit. A photographic copy of this authorization shall be considered as effective and as valid as the original.

I hereby authorize payments of insurance benefits otherwise payable to me to be made directly to PHILLIP R. FLESHNER, M.D./ KAREN N. ZAGHIYAN, M.D. I understand that I am ultimately financially responsible for charges not covered by their authorization. I also authorize that a photographic copy of this authorization is as if such copy were the original. If it becomes necessary for the account to be referred to an attorney for collection of suit, the undersigned shall pay all reasonable attorney fees and collection expenses.

A copy of the privacy policy of this office is available for my review in the waiting room.

Patient Signature: X_____ **Date: X**_____

Signature of Responsible Party: _____ **Date:** _____
(If applicable)

COMPREHENSIVE PATIENT HISTORY

PATIENT NAME: _____

Reason for visit today: _____

1. ALLERGIES TO MEDICATION(S) - INCLUDING TYPE OF REACTION

a.)_____ c.) _____ e.) _____
b.)_____ d.) _____ f.) _____

2. MEDICATION(S) YOU ARE TAKING - *Prescription and non-prescription, including aspirin, ibuprofen, Advil,or Ecotrin.* ***Please include dosage and frequency. You may attach a pre-printed list and write "see attached" below.***

PHARMACY Name: _____ **Phone Number:** _____

MEDICATION NAME	**DOSAGE** (ex: mg, ml, etc.)	**FREQUENCY** (ex: daily, 2x/day, etc.)
a.)		
b.)		
c.)		
d.)		
e.)		

3. MEDICAL HISTORY. - *Please indicate if you have or have had any of the following by* ***circling Yes or No, followed by a brief explanation, including dates.***

			Explanation & Dates
Cardiac Disease	Yes	No	_____
Mitral Valve Prolapse	Yes	No	_____
Artificial/Prosthetic Heart Valve	Yes	No	_____
Sleep Apnea	Yes	No	_____
Lung Disease	Yes	No	_____
Liver Disease/Hepatitis	Yes	No	_____
Kidney Disease	Yes	No	_____
Diabetes	Yes	No	_____
Cancer	Yes	No	_____
Seizure Disorders	Yes	No	_____
Hypertension	Yes	No	_____
Bleeding Disorder/Tendency	Yes	No	_____
Orthopedic Prosthesis/Implant	Yes	No	_____
Thyroid Disease	Yes	No	_____
Ulcer/Reflux	Yes	No	_____
Other:_____	Yes	No	_____

Cigarette Smoking: □ Never □ Quit □ < 1 pack/day □ 1-2 packs/day □ > 2 packs/day

(Women) Number of pregnancies: _____ Vaginal deliveries: _____ C-sections_____

4. SURGICAL HISTORY - *Please* ***list ALL OPERATIONS*** *that you have had and when they were done* ***including:***

Date of most recent **COLONOSCOPY**: _____ ***Date of most recent*** **SIGMOIDOSCOPY**: _____

_____

_____

_____

_____

5. FAMILY HISTORY - ***Please list any family history of colorectal cancer or polyps, cancers in other areas of the body, anal problems such as hemorrhoids or fissures, Crohn's Disease or ulcerative colitis. Indicate the relationship of each family member listed (mother, father, aunt, uncle, etc).***

_____

_____

_____

_____

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PATIENT PAYMENT AGREEMENT

READ each section below **then INTIAL EVERY BOX** to certify that you have been informed, understand and adhere to the following agreement.

☐ **I am primarily responsible to settle my account for all accrued/accumulated medical billing charges** of Dr. Phillip Fleshner/ Dr. Karen Zaghiyan, including but not limited to my co-pay, deductible, co-insurance and out of pocket maximums. I will cooperate in good faith with their billing office, especially if my insurance company denies or delays reimbursements of my charges.

☐ It is **my responsibility to provide the business office of Dr. Phillip Fleshner / Dr. Karen Zaghiyan with current and active insurance coverage at EVERY visit.** I agree to be fully responsible and immediately pay for care costs incurred if the insurance coverage I have provided is NOT active at the time services are rendered to me. I understand that this business office will not file my claim retroactively because I have provided expired/terminated insurance coverage.

☐ The business office of Dr. Phillip Fleshner/ Dr. Karen Zaghiyan may **extend the courtesy of billing my insurance company on my behalf**. In the event my insurance company sends me the payment for all or any portion of these charges, I am obligated to immediately remit that check to Dr. Fleshner's and/or Dr. Zaghiyan's office to be applied against my total charges, unless I have already paid these doctors in full for their charges.

☐ I understand that the above doctors may refer me to outside agencies, specialty practitioners, and/or specialty care providers that they feel may be necessary for my medical condition. In these occasions, I will be responsible for cost(s) for these services with such providers and that they will be billed separately to me.

☐ A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable

INSURANCE COVERAGE

ONLY INTIAL the BOX(es) best describing your insurance plan benefits/coverage. Our staff will verify your insurance coverage on your behalf.

☐ **I currently <u>DO NOT HAVE MEDICAL INSURANCE COVERAGE</u> that can be billed for services to be rendered to me by Phillip R. Fleshner, MD and/or Karen N. Zaghiyan, MD.** I understand that I will be responsible for charges IN FULL ON THE SAME DAY services are rendered by cash, Visa, or Mastercard prior to leaving their office. I will be provided with a receipt of charges.

☐ ***<u>OUT-of-NETWORK INSURANCE:</u>***
Phillip R. Fleshner, MD and/or Karen N. Zaghiyan, MD, **is <u>OUT-OF-NETWORK</u> and is <u>NOT</u> a participating provider for my medical insurance company -** _____. I understand that I will be responsible to pay for the charges due today prior to leaving the office. I will be provided a receipt of charges, which I can use to personally bill my insurance company.

☐ ***<u>DR. FLESHNER is an IN-NETWORK PROVIDER</u>* <u>only with MEDICARE, BLUE SHIELD PPO, and TRICARE SELECT (PPO).</u>** As a courtesy, the business office of Dr. Fleshner will bill my insurance company on my behalf and accept payments based on my in-network benefits - including my specialist co-pay, deductible, co-insurance – up to my out of pocket maximum.

☐ ***<u>DR. ZAGHIYAN is an IN-NETWORK PROVIDER</u>* <u>only with MEDICARE, BLUE SHIELD PPO, CIGNA PPO, and TRICARE SELECT (PPO).</u>** As a courtesy, the business office of Karen Zaghiyan, MD will bill my insurance company on my behalf and accept payments based on my in-network benefits - including my specialist co-pay, deductible, co-insurance – up to my out-of-pocket maximum.

Patient Name: X_____ **Name of Responsible Party:** _____
(For Minors ONLY)

Patient Signature: X_____ **Date: X**_____

Signature of Responsible Party: _____ **Date:** _____
(For Minors ONLY)

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PATIENT INFORMATION – CREDIT CARD ON FILE POLICY

Healthcare has undergone dramatic changes in the past few years. High-deductible health plans are now a mainstay in the healthcare landscape. This means that more responsibility of payment is being placed on patients. We want to help our patients maintain a good standing account in our office with balances paid in a timely manner. If you have ever stayed in a hotel or rented a car, you are familiar with the concept of having a credit card on file. Your credit information is stored in a secure, encrypted manner and you will be informed should it need to be accessed and charged for an outstanding balance due.

This is required to be seen in our office. Effective July, 1, 2023, Phillip R. Fleshner, MD and Karen N. Zaghiyan, MD have adopted a Credit Card on File Policy.

At the time of registration, you will need to provide a valid credit card for your file (ONLY the card types listed below). ***You may present the card to attach to this form or complete the information below with your signature.*** Your credit card numbers will be encrypted and stored securely off-site. Once we receive your Explanation of Benefits (EOB) – summary provided by your insurance company detailing what they will pay towards your visit – we will wait 90 days to allow time for you to pay the balance due on your account. Should your balance remain unpaid, our billing office will send you a notice to obtain your permission to charge the credit card on file for the outstanding balance outlined on your EOB as "patient responsibility". Specialist co-pays must be paid at the time of visit. For concerns and questions about this payment method, please contact our Billing Office at 310-289-9277.

How does having a CREDIT CARD ON FILE benefit me?
Using the CREDIT CARD ON FILE, you will be able to:

- Pay balances and co-pays conveniently
- Authorize automatic payments using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts sent via email

Please note that all of your rights with respect to the use of your credit card will remain in effect. This new policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination on payment/reimbursement.

Your signature is required as indicated. BOTH doctors accept Visa and MasterCard but only Dr. Zaghiyan accepts AMEX. The credit card number will be redacted prior to scanning this form into the Electronic Medical Record.

Your CREDIT CARD ON FILE can be used for the following reasons:

- Specialist copays at the beginning of the visit
- Outstanding balance greater than 90 days past due

Credit Card Type (circle one) **Visa** **MasterCard** **(*Dr. Zaghiyan ONLY*) AMEX**

Credit Card Number** _____ Security Code _____ Exp Date _____ Name on card (if different from Patient Name) _____

Billing Address (ONLY complete if different from mailing address already provided) _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

Patient Name _____ DOB _____ Name of Responsible Party (For Minors ONLY) _____ Relation to Patient _____

Patient Name _____ DOB _____ Patient Name _____ DOB _____

I authorize Phillip R. Fleshner, MD and Karen N. Zaghiyan, MD to charge the credit card above per the terms of this policy. This authorization shall remain in effect until I have sent a written notification of its termination.

Signature _____ Date _____