PATIENT PAYMENT AGREEMENT

READ each section below **then INTIAL EACH 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) which best describes your insurance plan benefits/coverage.

☐ **I currently DO NOT HAVE MEDICAL INSURANCE COVERAGE 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 receipt of charges.

☐ ***OUT-of-NETWORK INSURANCE:***
Phillip R. Fleshner, MD and/or Karen N. Zaghiyan, MD**, is OUT-OF-NETWORK and is NOT 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 directly for possible reimbursement.

☐ ***DR. FLESHNER is an IN-NETWORK PROVIDER* only with MEDICARE, BLUE SHIELD PPO, and TRICARE SELECT (PPO).** 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.

☐ ***DR. ZAGHIYAN is an IN-NETWORK PROVIDER* only with MEDICARE, BLUE SHIELD PPO, CIGNA PPO, and TRICARE SELECT (PPO).** 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 Signature: X_____ **Date: X**_____

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

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**

ESTABLISHED PATIENT – YEARLY CONSENT UPDATE

READ EACH SECTION CAREFULLY AND COMPLETE BOTH SIDES OF THIS FORM AS INDICATED.

PATIENT NAME: _____ Date of Birth: _____

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

CONSENT FOR RELEASE OF INFORMATION & TREATMENT

I hereby authorize PHILLIP R. FLESHNER, MD / KAREN N. ZAGHIYAN, MD and their office staff to disclose, when requested by my referring/primary physician, insurance carrier or its representatives, any and all patient-related information with respect of any illness(es), medical history, or treatment and copies of medical records. The same authorization applies to those listed I have listed during my first office visit. 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.

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

Signature of Responsible Party: _____ **Date:** _____

ASSIGNMENT OF BENEFITS/ PRIVACY POLICY

I hereby authorize payment to be made directly to PHILLIP R. FLESHNER, MD / KAREN N. ZAGHIYAN, MD of the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this 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 agency for collection of fees, I agree to pay the reasonable 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:** _____

ALL MEDICARE PATIENTS

****THIS PORTION MUST BE COMPLETED BY MEDICARE PATIENTS ONLY****

Patients who do NOT have Medicare coverage may skip this section.

Each year you have a Medicare deductible (2026 is $283.00), which must be satisfied before your Medicare insurance pays its share of your medical charges, usually 80%. Doctors Fleshner and Zaghiyan **ARE** Medicare providers and our billing office **WILL BILL** your Medicare insurance for you. However, if your deductible (or any portion thereof) is not satisfied, you will be responsible for paying that portion. **SSN is required and must be provided here: _____ -_____- _____** to BILL Medicare on your behalf.

If you have supplemental insurance(s) responsible for paying your deductible and/or charges, our billing office will also send an insurance claim to your supplemental coverage. Should there still be remaining unpaid balances *determined as your portion by your supplemental coverages(s),* our billing office will then send you a statement for such balances. This statement means that your insurance company(ies) have been billed and they have determined the amount listed as your responsibility. You will be responsible for settling your account with our billing office.

***For Medicare patients with Medi-CAL (Medicaid) supplemental coverage*: _____**

*Doctors Fleshner and Zaghiyan **ARE NOT** Medi-CAL providers and therefore cannot bill Medi-Cal for your Medicare deductible and charges not covered by Medicare. This means that you will be responsible for your deductible and care charges not covered by Medicare to continue your care in our office. You will need to pay $283 at your FIRST VISIT for this new year. Our billing office will continue to bill Medicare on your behalf as usual.*

I understand my financial responsibility in the above matter. I have been advised that I may request and be given a copy of this notice.

Patient Signature: _____ **Date:** _____