Maia U. Chakerian, M.D.
Payment Policy

Thank you for choosing to receive your pain management services from Maia U. Chakerian, M.D. Dr. Chakerian is committed to providing you with the best patient care possible. Dr. Chakerian recently revised her payment policy and is requiring that all new and existing patients provide a valid credit card number and authorization. In addition, patients will be requested to sign advanced beneficiary notices for services that may not be covered by insurance. In order to best serve you, we need your assistance and understanding of our payment policy.

Patients with Insurance Benefits: For a complete list of those insurance plans in which Dr. Chakerian participates, please ask our staff. If you are covered by a participating plan or any other health plan that will pay us directly, Dr. Chakerian will submit an insurance claim on your behalf for services rendered as follows:

In-Network Plans: If you are covered by a health plan in which Dr. Chakerian is "in-network", you will be required to pay your copayment at the time of service, and we will file a claim with your plan for the remaining balance. We will attempt to collect the full amount allowable from your insurance plan. However, you may still be responsible for deductibles, co-insurance, or other amounts depending on your insurance policy.

Out-of-Network Plans: If you are covered by a health plan in which Dr. Chakerian does not participate or if Dr. Chakerian is considered an "out-of-network" provider, you can pay for your charges at the time of service or we will file a claim with your plan for charges that are incurred. We will attempt to collect the full amount allowable from your insurance plan. However, in the event that the insurance company denies the claim or does not pay the full amount we will charge your credit card for the balance that is owed to us.

Self-Pay Patients: If you do not have health insurance benefits or if you do not want us to file an insurance claim on your behalf, then all charges are due at the time of service.

I have read and understand this Payment Policy. I hereby agree to take full responsibility for any and all charges incurred and hereby assign any and all insurance benefits to Silicon Valley Pain Management for services received.

Patient/Guarantor Signature: _____ Date: _____

Patient/Guarantor Name: _____

Maia U. Chakerian, M.D.

CREDIT CARD BILLING AUTHORIZATION FORM

I hereby authorize Maia U. Chakerian, M.D., to charge the credit or debit card account listed below for the balance of medical charges not paid by my insurance plan(s). I understand that if my credit or debit card information changes, I must notify Dr. Chakerian of the change.

PATIENT NAME: _____

CREDIT CARD INFORMATION

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

NAME ON CARD _____

BILLING ADDRESS _____

CITY, STATE, ZIP _____

DAY TIME PHONE NUMBER _____

CREDIT CARD NUMBER _____

3 Digit Code on Back of Card (CVA#) _____

EXPIRATION DATE _____

Signature _____