EliteCare Surgical Specialists Patient Financial Responsibility Consent – 2026

EliteCare Surgical Specialists is committed to providing exceptional care and transparent financial experience. By receiving care from Dr. Zahiri and/or EliteCare Surgical Specialists, you enter into a financial agreement with our practice. Please review the following terms carefully. Your signature below confirms your understanding and acceptance of these responsibilities.

1. **Identification Requirements** I agree to provide a valid government issued ID (driver's license, passport, etc.) with my current residential and mailing address. I understand that my ID will be scanned and stored only within the secure electronic health record. I acknowledge that EliteCare will never store my personal information outside the EHR.
2. **Credit Card on File Authorization** I agree to maintain an active credit card on file throughout my care. The card must share the same billing address as my government issued ID. I authorize EliteCare to charge this card for any outstanding balances, fees, or amounts owed. I understand that EliteCare will attempt to notify me of any balance using the contact information on file, but payment may be processed without additional authorization if the balance remains unpaid. If I dispute a charge, I understand that relevant medical information may be disclosed to my credit card company as needed to validate the services provided.

If another responsible party wishes to place their credit or debit card on file for my account, they must also provide a copy of their valid government issued identification. The name and billing address on the ID must match the card being placed on file.

Cardholder/Responsible Party Signature: _____

DOB: _____ Date: _____

3. **Payment Methods & Processing Fees** I acknowledge that a 2.99% processing fee applies to all credit card payments. I understand that cash and checks are accepted without additional fees.
4. **Insurance Responsibilities** I agree to verify my insurance benefits and confirm that Dr. Zahiri and/or EliteCare Surgical Specialists are covered providers under my plan. I understand that EliteCare submits claims as a courtesy, but I am financially responsible for all charges, including copayments, deductibles, and coinsurance. If my insurance does not pay within 60 days, I agree to pay the balance directly and seek reimbursement from my insurer. I agree to promptly communicate any insurance correspondence or requests for information. I understand that EliteCare bills only the contractually allowed amount per payer guidelines.
5. **Referrals, Testing, and Outside Providers** If I am referred for labs, imaging, or specialty care, I understand it is my responsibility to confirm coverage with my insurance. I acknowledge that EliteCare is not responsible for charges from outside providers who may be out of network.
6. **Out of Network Services** If EliteCare is out of network with my insurance, I understand that claims will still be submitted as a courtesy. I agree to pay any unpaid balances within 60 days.
7. **Payment at Time of Service** I agree that copayments, coinsurance, deductibles, and other fees are due at the time of service unless prior arrangements have been made. Accepted forms of payment include VISA, MasterCard, American Express, cash, or check.
8. **Insurance Changes** I agree to notify EliteCare immediately of any insurance changes, authorization requirements, or referral updates. Failure to do so may result in direct billing for unpaid charges.
9. **Self Pay Policy** If I am uninsured, I agree to the terms of the SelfPay Policy. I understand that new uninsured patients must pay the $350 consultation fee at the initial visit. Additional visits may incur charges depending on the care required. Routine postoperative visits included in the surgery price are not billed separately.
10. **Billing, Late Fees & Collections** I understand that a new bill is generated for each visit. Balances unpaid after 30 days will incur a 1.5% late fee. Accounts sent to collections will incur an additional 30% collections fee.
11. **Privacy & Information Sharing** I understand that EliteCare protects my privacy in accordance with HIPAA. I authorize the release of necessary personal, medical, and financial information to third parties (including insurance companies) for payment purposes.
12. **Returned Checks** I acknowledge that a $35 fee applies to all returned checks.

13. **No Show & Late Cancellation Policy** I agree to cancel or reschedule appointments at least 24 hours in advance. I may cancel by calling (301) 215-0127 or emailing Consult@elitecaress.com. I understand that repeated no shows or late cancellations may result in fees or dismissal from the practice.

Patient Acknowledgment & Consent By signing below, I acknowledge that:

I have read and understand the Patient Financial Responsibility Consent. I agree to comply with all terms listed above. I understand that failure to meet these responsibilities may result in additional fees or collection activity.

Print Patient Name: _____

Patient or Guardian Signature: _____

DOB: _____ Date: _____