THE
F·R·I·S·C·H·E·R
MEDICAL GROUP

Welcome to Frischer Medical Group

Office and Financial Policies

Thank you for choosing Frischer Medical Group. Our team is committed to providing you with compassionate, high-quality care. To ensure a smooth experience, please review the following policies:

Required Information for Appointments

To help us provide the best care, please bring the following to each visit:

- Valid insurance card
- Government-issued photo ID
- Current list of medications
- Contact information for previous physicians
- Preferred pharmacy name and phone number

Consent for Services

- By signing this policy, you authorize **Frischer Medical Group** to provide medical services as recommended by your provider. This includes exams, procedures, labs, imaging, and emergency care.

Insurance & Payment Policy

- **Co-pays and co-insurance** are due **before** your appointment.
- We are **legally required** to collect co-pays. Waiving them is considered **insurance fraud** and may result in penalties.
- If your insurance **cannot be verified** at the time of service, you must:
    - Pay as a **cash patient**, or
    - **Reschedule** your appointment.

Insurance Coverage

- It is your responsibility to understand your insurance benefits and limitations. Please contact your insurance provider with any questions regarding coverage

Non-Covered Services

- If your insurance denies coverage for a service, you are responsible for the full charge. Payment is due upon receipt of your billing statement.

Prescription Refill Policy

- Please allow **24 hours** for all prescription refills and new prescriptions.
- Plan ahead for **weekends and holidays**—we recommend requesting refills **4–5 days in advance**.
- For **mail-order prescriptions**, include a **self-addressed stamped envelope**.
- For **controlled substances**, you must:
    - Use **only one pharmacy**
    - Receive prescriptions **only from our office**
    - Failure to follow this policy may result in **termination of care**.

11480 Brookshire, Suite 200
Downey, CA 90241
Tel: (562) 806-0874 Fax: (562) 927-4801

THE
F·R·I·S·C·H·E·R
MEDICAL GROUP

Medical Records Requests

- Requests from **state agencies or other physicians** are prioritized.
- **Personal requests** may take up to **2 weeks**.
- The **first request** is typically free. For large or additional requests, a **$25 fee** applies.

Missed Appointments

- A **$25 fee** will be charged for:
  - No-shows
  - Cancellations made with **less than 24 hours' notice**

Form Completion Fee Schedule

Please see attachment for Form Completion Fee Schedule.

Medical Debt Disclosure

Under **Section 1785.27 of the California Civil Code**, any holder of this medical debt is **prohibited** from reporting it to a consumer credit reporting agency.
If this law is knowingly violated, the debt becomes **void and unenforceable**, and additional legal penalties may apply.

Contact Information

If you have any questions or concerns, please contact our Office Manager:
Roberta Orozco
Frischer Medical Group
We look forward to a long and positive relationship with you and are committed to supporting your healthcare needs for years to come.

Acknowledgment and Signature

I certify that I have read and fully understand the above policies. Any questions I had were answered to my satisfaction.

Patient's Name (please print): _____
Date of Birth: _____

Signature: _____
Today's Date: _____

If patient is a minor:
Parent/Guardian Name (please print): _____
Signature: _____
Date: _____

11480 Brookshire, Suite 200
Downey, CA 90241
Tel: (562) 806-0874 Fax: (562) 927-4801

THE F·R·I·S·C·H·E·R MEDICAL GROUP

Form Completion Fee Schedule

Attachment to Office Financial Policy

The following fees apply to all forms that require physician review, completion, or signature. **Payment is required in advance for all forms. No checks accepted.**

Form Type	Fee
State Disability	$25.00
State Disability Extension	$15.00
Physical Exam	$25.00
DMV Physical	$25.00
Family Medical Leave (FMLA)	$25.00
Nursing Home Forms	$25.00
Immigration Forms	$25.00
Disability Placard	$10.00
Jury Duty	$10.00
In-Home Care Form (1 page)	$10.00
In-Home Care Form (2 or more pages)	$20.00
Physician Report	$25.00

Important Notes:

- **All forms requiring physician completion are subject to a fee.**
- **Forms that need to be faxed must be paid for in advance.**
- **We do not accept personal checks.**

11480 Brookshire, Suite 200
Downey, CA 90241
Tel: (562) 806-0874 Fax: (562) 927-4801

THE
F·R·I·S·C·H·E·R
MEDICAL GROUP

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis,
including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health
care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____ _____
City /State/ Zip Code Phone no:

The medical information/records will be used for the following purpose: _____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Tests for Antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____ (initial)

DURATION: This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS:
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of Patient or legal/personal representative
Relationship if other than patient

_____ _____
Patient's Name (PRINT)
Date

_____ _____
Patient's Date of Birth
Patient's Social Security Number

_____ _____
Witness Name
Witness Signature

11480 Brookshire, Suite 200
Downey, CA 90241
Tel: (562) 806-0874 Fax: (562) 927-4801