F ♦ R ♦ I ♦ S ♦ C ♦ H ♦ E ♦ R

·Medical Group·

Welcome to Frischer Medical Group, we are sending you a registration pack prior to your appointment to fill out completely. Please be sure to bring this with you the day of your appointment, on _____ at __:__ with Dr._____. It is **MANDATORY** to bring your **INSURANCE CARD, VALID I.D. AND A CURRENT MEDICATION LIST** with you. If any required information is missing or not completed **we reserve the right to reschedule** your appointment at the next available date and time. We appreciate your cooperation and look forward to meeting all of your needs.

Alan A. Frischer, M.D.
William C. Sim, M.D.
Laura F. Ryan, M.D.
And Staff

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

PATIENT INFORMATION

Name:	Date of Birth:
Address:	Social Security #:
Apt. #:	Sex:
City:	Language:
State: Zip:	EMAIL:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone #:
Cell Phone#:	Emergency Relationship:
Employer Name:	Employer Address:
Race Circle: Asian, Caucasian, American Indian, AfricanAmerican, Other	Ethnicity: Hispanic, Caucasian, Asian Other

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member ID#:	Member ID#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider when he accepts assignment. I understand I am financially responsible for any balance not covered by my insurance.

Authorization To Release Medical Information: I hereby authorize my Provider, Frischer Medical Group to release any information necessary for my course of treatment.

_____ _____

Signed (Parent of Patient if minor) Date

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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.**

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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: _____

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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.**

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THE

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NOTICE TO PATIENTS

ABOUT MEDICAL BOARD and

OPEN PAYMENTS DATABASE

ACKNOWLEDGENT OF RECEIPT AND UNDERSTANDING

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

It can be found at https://openpaymentsdata.cms.gov.

Medical doctors are licensed and regulated by the Medical Board of California.

To check up a license or to file a complaint go to www.mbc.ca.gov

Email: licensecheck@mbc.ca.gov or call (800)633-2322

Patient's Full Name (Type or Print) _____ **Date** of Birth _____

Patient's Signature _____

Patient Representative's Name And Relationship (Type or Print) _____ **Date** _____

Patient's Representative's Signature _____

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1 FRISCHER MEDICAL GROUP

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. FRISCHER MEDICAL GROUP is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples.

    a. For treatment- Any diagnosis and/or history necessary to obtain authorizations or referrals for continuity of care.
    b. For payment- Any diagnosis and/or history related to the specific date of service in question will be provided in order to facilitate payment.
    c. For health care operations – Any diagnosis and/or history necessary in the study of clinical trials that this office may undertake. In such trials, names of individuals are not disclosed. Relevant diagnoses and history only will be used in conjunction with the study after the individual gives signed consent to participate.

2. Frischer Medical Group is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. [If a use or disclosure for any purpose prescribed in the Privacy Regulation is prohibited or materially limited by other applicable State law, the description of such use or disclosure must reflect the more stringent law.]
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Frischer Medical Group intends to engage in (n)one or more of the following activities:
    a. Frischer Medical Group may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
    b. Frischer Medical Group may contact the individual/Patient to raise funds for Frischer Medical Group; or
    c. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The Individual has the following rights regarding protected health information:
    a. The right to request restrictions on certain uses and disclosures of protected health information. *Frischer Medical Group* is not required to agree to a requested restriction, however.

b. The right to receive confidential communications of protected health information, as applicable.
c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
d. The right to amend protected health information, as provided in the Privacy Regulation.
e. The right to receive an accounting of disclosures of protected health information.
f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to and individual who has agreed to receive the Notice electronically

6. *Frischer Medical Group* is required by law to maintain the privacy of protected health information and provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.

7. *Frischer Medical Group* is required to abide by the terms of the Notice currently in effect.

8. *Frischer Medical Group* reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

9. *Frischer Medical Group* will provide individuals or patients with a revised Notice by personally handing the patients a revised notice as they come in or by mail, whichever comes first.

10. Individuals may complain to *Frischer Medical Group* and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual listed below, give a detailed explanation as to why you believe your privacy rights have been violated.

11. *Frischer Medical Group*'s contact person for matters relating to complaints is:
    a. Roberta Orozco
    b. 562-806-0874
    c. 11480 Brookshire Ave #200 Downey, Ca 90241

12. This Notice is first in effect on (Date given to patient)

13. Frischer medical Group elects to limit the uses or disclosures that it is permitted to make, as follows: No limitations at this time.

I hereby acknowledge that I have received a copy of Frischer Medical Group's Notice of Privacy Practices._____ Date:_____

Individual's Name

Frischer Medical Group
Consent for Release of
Protected Health Information

I,_____, consent to the release of protected health information that is required to carry out treatment, payment of healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Frischer *Medical Group* is not required to agree with my requested restrictions. I also understand that once *Frischer Medical Group* agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- *Frischer Medical Group* has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you either in person or by mail.

Individual:	Witness:
_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Date	Date