PATIENT INFORMATION GUIDE

PACIFIC OAKS

Thank you for becoming a patient at Pacific Oaks Medical Group!

Please be assured that everyone in this practice is dedicated to providing medical care of the highest quality possible to all of our patients, in an atmosphere of caring, trust and mutual respect.

The information provided below will help you navigate the complex medical system and receive efficient, high quality care. Pacific Oaks Medical Group is committed to help you in any way possible. If you have any questions or concerns please give us a call at 310-652-2562 and we will do our best to assist you.

INTRODUCTION: The purpose of this patient information guide is to provide you with general information regarding Pacific Oaks Medical Group and your Primary Care Providers (PCP) in particular. The goal of our medical practice is to create a safe, caring, convenient and affordable health care environment for you. We acknowledge that, even with the best of intentions, the delivery of quality health care can present some formidable challenges. We hope that the following patient information guide will prove to be a useful resource for you.

IMPORTANT TELEPHONE NUMBERS:
Main Office Number: 310-652-2562
Emergencies After Hours: 310-652-2562
Office Fax: 310-967-3698

OFFICE HOURS		**TELEPHONE HOURS:**
Monday-Thursday	8:00 am – 6:00 pm	AM 8:00A-12:00P
Lunch Hours from	12:30 pm – 1:30 pm	PM 1:30P-5: 30P
Friday Hours	8:00 am – 5:00 pm	Fridays 1:30P-4:30P

EMERGENCIES & AFTER HOURS PROBLEMS:

LIFE THREATENING EMERGENCIES: Dial 911 - the paramedics will take you to the nearest emergency room

DURING OFFICE HOURS: Ask the receptionist to give an "URGENT" message to your PCP or his Medical Assistant (MA) directly. You may be instructed to call 911, go to the Cedars-Sinai emergency room, or to come to the Beverly Hills office for immediate evaluation.

AFTER OFFICE HOURS: Call 310-652-2562 and ask the operator to page the Pacific Oaks doctor on call - your call will be returned promptly by the on-call doctor. Please note that this option is for EMERGENCY SITUATIONS ONLY. Routine issues like medication refills and non-emergency medical problems should wait until the office opens on the next business day.

SAME-DAY & URGENT APPOINTMENTS: If you need to see your PCP on the same day for an urgent medical issue, it is suggested that you call our receptionist as early as possible in the day (8:00 AM). That way we may accommodate your appointment needs. Since we do not accept walk-in patients or "double-book" patients, your telephone call will ensure that the PCP will be in the office and can evaluate you personally. There are three options available to you:

1. Appointment with your PCP who always will do his best to accommodate patients with urgent medical needs.

a) Same-Day appointments, if approved by PCP, are scheduled to be more brief than the regular appointments and are intended to address simple but urgent medical issues. There is an additional fee for Emergency Services of $50.00 which your insurance company may or may not pay. You are ultimately responsible for this fee.

b) Common sense and good medical practice prohibit the doctor from overbooking his regular patient schedule to the point where he is no longer able to deliver effective medical care. If your PCP is fully booked on a given day, you will be directed to another Pacific Oaks Practitioner who will triage your urgent medical needs and communicate to your PCP what was done. The PCP will then follow up with you personally.

2. Another Pacific Oaks Medical Doctor.

One of the greatest benefits of practicing medicine in a well-integrated medical group is that there are always other Physicians available to accommodate your urgent medical needs if the PCP is not in the office or is fully booked. All of Pacific Oaks' physicians are *board-certified* – a distinction which guarantees you the highest level of medical expertise.

3. Cedars-Sinai Emergency Department.

The best option for a life-threatening emergency (e.g. serious accident, heart attack, seizure, etc.). For inpatient care and emergencies, our Doctors refer their patients to Cedars-Sinai Medical Center. Their main telephone number is 310-423-5000.

MESSAGES: All telephone calls will be returned within 48 hours unless otherwise specified to you. Please leave your name, home and work telephone numbers, and pharmacy telephone number so that we can reach you as quickly as possible. ***Please note:*** *our front office and MA staff are discreet and are specially trained - the more detailed the information you can leave with them, the better we will be able to handle your needs.*

GENERAL QUESTIONS: Please leave a detailed message, your name and telephone number and a good time to call you back. Also, please indicate if we may leave a detailed reply on your answering machine.

TEST RESULTS: Please call us to discuss your test results. If there are abnormal or problematic results, you may be asked to return for a follow-up with your PCP. Also, if you have a specific question that is beyond the scope of the MA's training, please ask to speak to your PCP directly and your call will be returned within 24-48 hours. Test results can take up to 14 days.

PRESCRIPTION REFILLS: The best medical care occurs when you are seen regularly. If you have not been seen for a while for an ongoing issue, or you are requesting a prescription for a new problem, we may insist on an office visit. **We cannot effectively, and in most cases will not treat problems over the phone.** Prescriptions are best refilled at the time of your office visit. If for some reason you are in need of a refill, please call during business hours and allow a turnaround time of two business days. **Please remember it is your responsibility to keep track of your medication quantity and call for your refills in an appropriate timeframe to schedule your office visit prior to running out of medication. Pharmacy calls and faxes will not be approved. Controlled drug (narcotic) and/or antibiotics prescriptions will not be refilled after hours, on weekends or by the On-Call Physician.**

MEDICAL ASSISTANT STAFF: We cannot say enough about our team of MAs. Nowhere else will you find a more dedicated, informed, and caring group of professionals in Los Angeles. They are the direct line of communication with the doctor and are an invaluable resource.

INSURANCE: Although we make every effort to have a general working knowledge of individual insurance policies the sheer number of them makes it impossible for us to know specifics of your plan. **Knowledge of the details of you insurance policy and its requirements is your responsibility.** However, POMG is happy to assist by educating our Patients select the best policy offered by insurance companies. Please feel free to contact Gilbert Villareal at 310-652-2562 ext.3339. Gilbert has 20 years experience working with benefit plans for all commercial and private carriers, including Medicare.

REFERRALS: **It is your responsibility to know if the Specialist is in your insurance network and to make sure that any prior authorization certifications have been completed.** As you Primary Care Provider we should always be included in your care by a Specialist. **Please understand that we will not provide referrals for non-urgent visits to ambulatory care facilities or emergency rooms.** If you're seen in one of those facilities and are referred to a specialist it is more important to make a follow up appointment with your PCP so that he can expedite and advocate on your behalf for any additional care needed.

PACIFIC OAKS MEDICAL GROUP
(POMG)

FINANCIAL POLICY

Our practice policy requires that prior to any services being rendered; all patients must sign the practice financial policy.

In order to become a "provider" of medical services through your health plan, the physicians at **POMG** are required to enter into a contract with selected insurance companies. Many such contracts stipulate that the physicians will not provide or charge for "unnecessary medical service," as determined by the insurance companies. Past experience has shown that some "health plans" have very different ideas than members, such as yourself, with respect to what is or is not "medically necessary".

This asserts your conviction that the described services rendered are appropriate and "necessary" as far as you are concerned, irrespective of the determination of your insurance company.

In the more recent years it has become increasingly difficult to collect the fees rightfully due to the provider for services rendered, in good faith, to their patients. To this end we have found it necessary to be very explicit in our financial polices of this practice. All too often we are finding patients presenting to the office stating they have no form of payment for the services they are about to receive, we ask that you please present to the office with a form of payment to meet your obligations to your insurance provider and to your healthcare provider.

We thank you in advance for taking the time to review these policies and your understanding of our need to have in place such an in depth policy.

Please feel free to discuss any concerns or questions you may have with anyone of our billing staff or our practice manager. We would welcome the opportunity to assist you in your understanding the complexities of health insurance today.

Things to bring with you to your visit:

- Health Insurance Card – we are required to verify these with a government approved form of ID
- Drivers License
- Method of payment – for your convenience we accept credit cards, debit cards, checks and cash.

Assignment of Benefits:

- Pacific Oaks Medical Group will only bill contracted insurance plans as a courtesy to our patients provided that the patient has provided the required insurance information in a timely manner and has signed a current financial policy.

Appointment cancellation, rescheduling and no-shows

- Your appointment will be confirmed by our confirmation service, 48 hours before your appointment, this will allow you to cancel and re-schedule your appointment should you need to.
- If you do not show for your appointment, cancel or reschedule within 12 hours of your appointment time, we will be bill you a fee of $75.

Additional Testing:

- For preventative care exams the physician may request you to undergo certain additional screening tests (CBC, CHEM, TSH, CRP), gonorrhea, Chlamydia screening, mental health benefits (libido issues, depression, anxiety), pap smears). Please contact your insurance company to determine if these are covered benefits to avoid incurring charges for which you will be held responsible.

Cash Pay/Fee for Service

- We offer a reasonable discount for our cash pay/fee for service patients who have no health insurance coverage in any form. Please advise front office staff upon check-in.
- You will be required to pay in full at time of check out on the day of your appointment. In the event your provider carries out additional procedures/tests, you will be required to pay for these at the time of check out.

Charges for copies of medical records

- You will be charged for copies of medical records as per Medical Association, State and Federal guidelines. These charges cover the administrative costs of copying and mailing such records.

Co-pay and co-insurance:

- We are obligated to collect the co-pay and co-ins at the time of your visit, even if you are sick. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy. If you receive two different types of services on the same day, you will be asked to pay two co-pay amounts as required by your insurance plan.
- All payments are due at time of service.

Deductibles:

- Some insurance plans require that patients pay a predetermined dollar amount prior to services being covered. If verification of your deductible is unable to be made, payment of the full deductible is due at time of service.

Filing Secondary Insurances

- We will file charges with your secondary insurance carrier as a courtesy to our patients.

FMLA and other Disability Paperwork

- The best way to take care of any forms that your PCP must fill-out for you is to come into the office. Please call our office to make an appointment and advise that you're coming in for paperwork. In extreme cases, where you are physically unable to come in, please allow the office 10 business days in which to review your medical record for the information requested, to be completed, copied and mailed or faxed. There will be a convenience item charged to you which your insurance company will not cover.

Health Savings Accounts / Healthcare Debit Cards:

- These cards carry a high deductible and you are responsible for payment of all healthcare services in full, at the time of service. If we are contracted with the health insurance with which you have this kind of plan, we may only bill you the full amount of our contracted allowable fee.
- We ask that you do not ask us to bill you for services rendered, we will require payment in full at time of service.

Hospital Admission related bills

- Our fees do not include these services or service rendered by the hospital or other attending physicians during any hospital treatment or surgery.

Insurance:

- We are contracted with multiple insurers to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment, co-insurance and deductible at the time of service.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a cash pay patient and will be provided documentation to assist you in filing your claim
- 48 hours notice is required to verify insurance benefits; and thus failure to notify the office with insurance changes or presenting without an insurance card may result in rescheduling of your appointment. If we are unable

- to verify your benefits should you have new insurance at the time of checking in for your appointment, we will ask that you pay for your visit in full.

Laboratory, Radiology and other diagnostic services bills

- Please check with your insurance company to verify what your schedule of benefits allows for any laboratory, x-ray or other diagnostic studies (bone densitometry, etc.) that may be ordered by the doctor during your visit and are sent out to other laboratories. *These services will be billed separately by the laboratory/ diagnostic facility that does these tests and are not covered by the payments that you make at this office*. Any insurance claims or problems associated with an off-site laboratory must be dealt with through that facility or their billing agent.

Medicare Patients

- Please make sure you have a full understanding of your Medicare benefits and what might be your responsibility if not covered by Medicare.
- *Your doctor wants to diagnose a condition you may have or evaluate how well your treatment is working. To do that the doctor needs to have certain diagnostic tests performed. The doctor will tell you what those tests are and why they are necessary. Before your tests are performed, you may be asked to sign an Advanced Beneficiary Notice or "ABN".* ***Why do we ask you to sign the ABN?*** We ask patients to sign an ABN whenever Medicare/Insurance Company appears likely to deny payment for a specific service. Medicare requires that we provide patients with a written notification whenever it is likely that you will be responsible for the bill. Please ask our staff for a brochure that will help you understand the ABN or see the attached What is an Advance Beneficiary Notice (ABN).pdf

Outstanding balances/ Collections:

- Prior to providing additional services to you, payment in full of total outstanding balances will be required.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections and written off to bad debt will be discharged from the practice.
- Outstanding balances that are greater than 30 days old will be referred to an outside collection agency. Once we receive an EOB (explanation of medical benefits) from your insurance, we will mail you a statement. If we do not receive payment within 30 days, your account will be referred to a collection agency.

Referral for Outside collection:

- Accounts which have not been paid according to the financial policy will be referred to an outside collection agency/attorney for further action.
- The patient's care with POMG may be terminated and the patient may be required to seek an alternative medical provider.

Patient Responsibility:

- Understanding of benefits: It is the patient's responsibility to call their insurance company and find out what your schedule of benefits allows and what services they will and will not cover.

Payment Responsibility:

- The patient or her legal representative is ultimately responsible for all charges for services rendered.
- "Non-covered" means that a service will not be paid under your insurance contract. If non-covered services are provided, you will be expected to pay for these services at the time they are provided. We cannot offer services without expectation of payment, and if you receive non-covered services, you must agree to pay for these services in the event that your insurance company does not.
- If you are unsure whether a service is covered by your plan, ultimately it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies and your potential financial responsibility.

Phone Appointments

- If you need to discuss a healthcare issue or abnormal test results, you will be asked to schedule an appointment to see your provider; they are no longer able to do this by phone.

Advance Beneficiary Notice (ABN)

1. What is an ABN?
An ABN is a form that lets you know that you may have to pay for a service/test your doctor has ordered if your Insurance refuses to pay for it. If you sign the ABN, the doctor's office may bill you for the cost of the service/tests.

2. Why do you want me to sign the ABN?
Although Insurance programs pay for most services/tests, it won't pay for some under certain circumstances. If that happens, the doctor's office must ask the patient to pay. Consequently, patients are asked to sign an ABN whenever Insurance appears likely to deny payment for the service/test the doctor has ordered.

3. Why don't you think Insurance will pay for this service/test?
Insurance pays only for services that it considers to be "medically necessary." Some services/tests are never considered medically necessary. Some services are always considered medically necessary. But most services fall in the middle: They're medically necessary only under certain circumstances, depending on what the patient's diagnosis is. If the diagnosis the doctor lists isn't one of the diagnoses Insurance will accept for that service/test the service won't be considered medically necessary and Insurance won't pay for it.

4. If Insurance says the service/test isn't medically necessary, then why perform it?
Your doctor has made a medical judgment that you need the service/test. When your doctor says a service/test is medically necessary, he/she considers your personal medical history, any medications you may be taking, and generally accepted medical practices. When Insurance says a service/test isn't medically necessary, it's not making a medical decision about your health. It's acting like an insurance company deciding what it will pay.

5. Must I sign the ABN?
No. You have three options:
Option I: You may sign the ABN and have the service/test performed. You can then be billed for the service/test.
Option II: You may refuse to sign the ABN and choose not to have the service/test performed. However, in not having the service/test performed, you'll be going against the medical advice of your doctor.
Option III: You may refuse to sign the ABN and go ahead with the service/testing. The doctor's office will perform the service/test and you'll receive a bill—even though you refused to sign the ABN. A witness will sign the ABN to indicate that you've been advised of the ABN, refused to sign it, but still want the service/test performed. **Under Insurance guidelines, the office may then directly bill you for the services.**

6. Will I be billed automatically?
No. We'll ask your Insurance to pay for it. Of course, if Insurance does pay for it, you won't receive a bill. You'll get a bill only if Insurance denies the claim. Remember that if Insurance denies the claim, you may contest the denial of the service/test.

7. Is Insurance more or less likely to pay if I sign?
Neither. The fact that you've signed an ABN won't affect Insurance's decision either way.

8. How much must I pay for the service/test?
Ask your provider.

9. Will supplemental insurance pay for the service/test if Insurance doesn't?
Maybe. Contact your insurance company and ask whether the policy covers services not covered by Insurance. If so, find out how to submit claims for payment under the policy.

10. Must I sign an ABN every time a new service/test is done?
No. You'll be asked to sign an ABN only when the doctor has a good reason to think that your Insurance will deny payment for the ordered service/test. So there may be visits to the doctor's office when you'll be asked to sign an ABN and other visits when you won't. It all depends on the service/test and the reason for ordering it on that visit.

11. I've never had to pay for a lab service/test before. Is this something new?
The ABN isn't new—it has been around for 10 years. But more offices are using it nowadays because of recent changes in how Insurance pays for services. And since some services aren't getting paid by Insurance, they must ask the patients to pay. This explains why ABNs are becoming more common.

12. You say the ABN isn't new. But I've never been asked to sign one before. Why must I sign one today?
There was no reason to believe Insurance would deny payment for the services the doctor ordered for you during previous visits. On other visits when you didn't have to sign an ABN, here are some likely possibilities:
_ Your doctor ordered different services on previous visits. This is the first time he/she is ordering this particular service/test;
_ This is the same service/test your doctor ordered before but your diagnosis has changed, that is, the doctor is ordering the service/test for a different reason; or
_ This is the same service/test and the same diagnosis. But since your last service/test, Insurance changed the rules and no longer pays for the service/test under the diagnosis.

NOTICE OF NONDISCRIMINATION

Pacific Oaks Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pacific Oaks Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Pacific Oaks Medical Group:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Amy Nasibian, General Manager.

If you believe that **Pacific Oaks Medical Group** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Pacific Oaks Medical Group, Amy Nasibian, General Manager**, 150 N Robertson Blvd., Suite 300, Beverly Hills, CA 90211, 310.652.2562, 310.967.3698 Fax. You can file a grievance in person or by mail, fax. If you need help filing a grievance, **Amy Nasibian, General Manager** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

English	ATTENTION: If you speak **English**, language assistance services, free of charge, are available to you. Call 1-800-443-0815 (TTY: 711)
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-443-0815 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-443-0815 (TTY：711).
Vietnamese	CHÚ Ý: NếubạnnóiTiếngViệt, cócácdịchvụhỗtrợngônngữmiễnphídànhchobạn. Gọisố1-800-443-0815 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalitaka ng Tagalog, maaarikanggumamit ng mgaserbisyo ng tulongsawikanangwalangbayad. Tumawagsa 1-800-443-0815 (TTY: 711).
Korean	주의: 한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다. 1-800-443-0815 (TTY: 711)번으로전화해주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝Եթեխոսումեքհայերեն, ապաձեզանվճարկարողենտրամադրվելեզվականաջակցությանծառայություններ: Զանգահարեք 1-800-443-0815 (TTY (հեռատիպ)՝ 711).
Russian	ВНИМАНИЕ: Еслывыговоритенарусскомязыке, товамдоступныбесплатныеуслугиперевода. Звоните1-800-443-0815 (телетайп: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-443-0815（TTY:711）まで、お電話にてご連絡ください。
Arabic	تنبيه: إذاكنتتتكلمالعربية،وخدماتالمساعدةاللغوية،مجانا،تتوفرلك. دعوة 1-800-443-0815 (TTY: 711)
Punjabi	ਧਿਆਨ: ਜੇਕਰਤੁਹਾਨੰਪੰਜਾਬੀ , ਭਾਸ਼ਾਸਹਾਇਤਾਸੇਵਾ , ਮੁਫ਼ਤਮੱਿ ਲਬਧਹਾ, ਜੇ, ਤੁਹਡੇਲਈਉਪਲੱਬਧਹਨ. 1-800-443-0815ਨੰਕਾਲਕਰੋ (TTY: 711)
Cambodian	ប្រយ័ត្ន៖បើសិនជាអ្នកនិយាយភាសា, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួលគឺអាចមានសំរាប់បំរើអ្នក។ចូរទូរស័ព្ទ 1-800-443-0815 (TTY: 711)។
Hmong	LUS CEEV: YogtiaskojhaislusHmoob, covkevpabtxoglus, muajkevpabdawbraukoj. Hu rau1-800-443-0815 (TTY: 711).
Hindi	ध्यानदें: यदिआपहिंदीबोलतेहैंतोआपकेलिएमुफ्तमेंभाषासहायतासेवाएंउपलब्धहैं।1-800-443-0815 (TTY: 711) परकॉलकरें।
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรีโทร1-800-443-0815 (TTY: 711).
Farsi	توجه: اگربهزبانفارسیگفتگومیکنید،تسهیلاتزبانیبصورترایگاندرامتاس بگیرید.1-800-443-0815 (TTY: 711) فراهمیباشد. با

PACIFIC OAKS

RESEARCH DEPARTMENT

As an avenue to the advancement of future therapies Pacific Oaks offers patients the opportunity to participate in Pharmaceutical Research.

The Clinical Research Department at Pacific Oaks Medical Group strives to accomplish one goal: To advance comprehensive health care solutions for tomorrow with clinical research today. We do this through partnerships with pharmaceutical companies developing the latest therapies and providing access to those therapies within ethically conducted clinical trials. For over 20 years Pacific Oaks has been conducting clinical research with this goal in mind.

Pacific Oaks is always looking for the opportunity to serve our Patients by providing access to the therapies of the future in clinical trials today. Pacific Oaks' primary goal is the safety, and benefit of the patient, which is why all studies are closely monitored by Pacific Oaks' Physicians.