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Code: Section:

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BUSINESS AND PROFESSIONS CODE - BPC

DIVISION 2. HEALING ARTS [500 - 4999.129] (*Division 2 enacted by Stats. 1937, Ch. 399.)*

CHAPTER 1. General Provisions [500 - 865.2] (*Chapter 1 enacted by Stats. 1937, Ch. 399.)*

ARTICLE 6. Unearned Rebates, Refunds and Discounts [650 - 657] (*Article 6 added by Stats. 1949, Ch. 899.)*

650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients that is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services, donations, loans, or a combination thereof to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be authorized only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic, including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code, or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility, provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56632 and 56644), and as subsequently amended.

(f) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Public Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(g) Notwithstanding this section or any other law, the payment or receipt of consideration for advertising, wherein a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. The fee paid to the third-party advertiser shall be commensurate with the service provided by the third-party advertiser. If the licensee determines, after consultation with the purchaser of the service, that the service provided by the licensee is inappropriate for the purchaser or if the purchaser elects not to receive the service for any reason and requests a refund, the purchaser shall receive a refund of the full purchase price as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee. The licensee shall disclose in the advertisement that a consultation is required and that the purchaser will receive a refund if ineligible to receive the service. This subdivision shall not apply to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, or essential health benefits, as defined in Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code. The entity that

provides the advertising shall be able to demonstrate that the licensee consented in writing to the requirements of this subdivision. A third-party advertiser shall make available to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser in the applicable geographic region. In any advertisement offering a discount price for a service, the licensee shall also disclose the regular, nondiscounted price for that service.

(h) To the extent consistent with federal law, regulations, or guidance, the payment or receipt of consideration for internet-based advertising, appointment booking, or any service that provides information and resources to prospective patients of licensees shall not constitute a referral of a patient if the internet-based service provider does not recommend or endorse a specific licensee to a prospective patient.

(i) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding fifty thousand dollars (\$50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by that imprisonment and a fine of fifty thousand dollars (\$50,000).

(Amended by Stats. 2021, Ch. 439, Sec. 3. (AB 457) Effective January 1, 2022.)

650.01. (a) Notwithstanding Section 650, or any other provision of law, it is unlawful for a licensee to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or their immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) "Diagnostic imaging" includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A "financial interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, "direct or indirect payment" shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of their research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, "consulting fees" means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for their ongoing services in making refinements to their medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A "financial interest" shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A "financial interest" shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

(3) For the purposes of this section, "immediate family" includes the spouse and children of the licensee, the parents of the licensee, and the spouses of the children of the licensee.

(4) "Licensee" means all of the following:

(A) A physician as defined in Section 3209.3 of the Labor Code.

(B) A nurse practitioner practicing pursuant to Section 2837.103 or 2837.104.

(C) A certified nurse-midwife as described in Article 2.5 (commencing with Section 2746) of Chapter 6, acting within their scope of practice.

(5) "Licensee's office" means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when licensure or certification is required by law.

(6) "Office of a group practice" means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the licensees who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, except in the case of a multispecialty clinic, as defined in subdivision (l) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(d) No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(f) A licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest, other than as prohibited by subdivision (a), shall disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or more licensees who contract with a multispecialty clinic pursuant to subdivision (l) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of this subdivision may be met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician and surgeon, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a certified nurse-midwife, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars (\$5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars (\$15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

(Amended by Stats. 2020, Ch. 265, Sec. 1.5. (AB 890) Effective January 1, 2021.)

650.02. The prohibition of Section 650.01 shall not apply to or restrict any of the following:

(a) A licensee may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 650.01 if the licensee's regular practice is located where there is no alternative provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. If an alternative provider commences furnishing the good or service for which a patient was referred pursuant to this subdivision, the licensee shall cease referrals under this subdivision within six months of the time at which the licensee knew or should have known that the alternative provider is furnishing the good or service. A licensee who refers to or seeks consultation from an organization in which the licensee has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.

(b) A licensee, when the licensee or his or her immediate family has one or more of the following arrangements with another licensee, a person, or an entity, is not prohibited from referring a patient to the licensee, person, or entity because of the arrangement:

(1) A loan between a licensee and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.

(2) A lease of space or equipment between a licensee and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.

(3) Ownership of corporate investment securities, including shares, bonds, or other debt instruments that may be purchased on terms generally available to the public and that are traded on a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the licensee's referral of persons to the corporation, do not have a separate class or accounting for any persons or for any licensees who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous three fiscal years, stockholder equity exceeding seventy-five million dollars (\$75,000,000).

(4) Ownership of shares in a regulated investment company as defined in Section 851(a) of the federal Internal Revenue Code, if the company had, at the end of the company's most recent fiscal year, or on average during the previous three fiscal years, total assets exceeding seventy-five million dollars (\$75,000,000).

(5) A one-time sale or transfer of a practice or property or other financial interest between a licensee and the recipient of the referral if the sale or transfer is for commercially reasonable terms and the consideration is not affected by either party's referral of any person or the volume of services provided by either party.

(6) A personal services arrangement between a licensee or an immediate family member of the licensee and the recipient of the referral if the arrangement meets all of the following requirements:

(A) It is set out in writing and is signed by the parties.

(B) It specifies all of the services to be provided by the licensee or an immediate family member of the licensee.

(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(D) A person who is referred by a licensee or an immediate family member of the licensee is informed in writing of the personal services arrangement that includes information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee.

(E) The term of the arrangement is for at least one year.

(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(c) (1) A licensee may refer a person to a health facility, as defined in Section 1250 of the Health and Safety Code, or to any facility owned or leased by a health facility, if the recipient of the referral does not compensate the licensee for the patient referral, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a licensee solely because the licensee has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A licensee may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code.

(4) A licensee may refer a person to any organization that owns or leases a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code if the licensee is not compensated for the patient referral, the licensee does not receive any payment from the recipient of the referral that is based or determined on the number or value of any patient referrals, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b). For purposes of this paragraph, the ownership may be through stock or membership, and may be represented by a parent holding company that solely owns or controls both the health facility organization and the affiliated organization.

(d) A licensee may refer a person to a nonprofit corporation that provides physician services pursuant to subdivision (l) of Section 1206 of the Health and Safety Code if the nonprofit corporation is controlled through membership by one or more health facilities or health facility systems and the amount of compensation or other transfer of funds from the health facility or nonprofit corporation to the licensee is fixed annually, except for adjustments caused by physicians joining or leaving the groups during the year, and is not based on the number of persons utilizing goods or services specified in Section 650.01.

(e) A licensee compensated or employed by a university may refer a person for a physician service, to any facility owned or operated by the university, or to another licensee employed by the university, provided that the facility or university does not compensate the referring licensee for the patient referral. In the case of a facility that is totally or partially owned by an entity other than the university, but that is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physicians for those referrals.

(f) The prohibition of Section 650.01 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a licensee's office, or the office of a group practice. Further, the provisions of Section 650.01 shall not alter, limit, or expand a licensee's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice.

(g) The prohibition of Section 650.01 shall not apply to cardiac rehabilitation services provided by a licensee or by a suitably trained individual under the direct or general supervision of a licensee, if the services are provided to patients meeting the criteria for Medicare reimbursement for the services.

(h) The prohibition of Section 650.01 shall not apply if a licensee is in the office of a group practice and refers a person for services or goods specified in Section 650.01 to a multispecialty clinic, as defined in subdivision (l) of Section 1206 of the Health and Safety Code.

(i) The prohibition of Section 650.01 shall not apply to health care services provided to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(j) The prohibition of Section 650.01 shall not apply to a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, or a request by a radiation oncologist for radiation therapy if those services are furnished by, or under the supervision of, the pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician.

(k) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(l) This section shall become operative on January 1, 1995.

(Amended by Stats. 2002, Ch. 309, Sec. 1. Effective January 1, 2003.)

650.1. (a) Any amount payable to any hospital, as defined in Section 4028, or any person or corporation prohibited from pharmacy permit ownership by subdivision (a) of Section 4111 under any rental, lease or service arrangement with respect to the furnishing or supply of pharmaceutical services and products, which is determined as a percentage, fraction, or portion of (1) the charges to patients or of (2) any measure of hospital or pharmacy revenue or cost, for pharmaceuticals and pharmaceutical services is prohibited.

(b) Any lease or rental arrangement existing on the effective date of this section shall be in full compliance with subdivision (a) by January 1, 1986.

(c) Any lease or rental agreement entered into prior to January 1, 1980, that extends beyond the effective date of this section shall be construed to be in compliance with this section until its expiration or the expiration of any option which is contained in any such lease or rental agreement provided that the lease or rental agreement contains provisions which limit pharmacy charges to the amounts not in excess of the prevailing charges in similar hospitals in the general geographic area.

(d) The California State Board of Pharmacy, the Medical Board of California, and the State Department of Health Services shall enforce this section and may require information from any person as is necessary for the enforcement of this section. It shall be the

duty of the licensees of the respective regulatory agencies to produce the requisite evidence to show compliance with this section. Violations of this section shall be deemed to be the mutual responsibility of both lessee and lessor, and shall be grounds for disciplinary action or other sanctions against both.

(Amended by Stats. 2000, Ch. 836, Sec. 1. Effective January 1, 2001.)

650.2. (a) Notwithstanding Section 650 or any other provision of law, it shall not be unlawful for a person licensed pursuant to Chapter 4 (commencing with Section 1600) of Division 2 or any other person, to participate in or operate a group advertising and referral service for dentists if all of the following conditions are met:

- (1) The patient referrals by the service result from patient-initiated responses to service advertising.
- (2) The service advertises, if at all, in conformity with Section 651 and subdivisions (i) and (l) of Section 1680.
- (3) The service does not employ a solicitor within the meaning of subdivision (j) of Section 1680.
- (4) The service does not impose a fee on the member dentists dependent upon the number of referrals or amount of professional fees paid by the patient to the dentist.
- (5) Participating dentists charge no more than their usual and customary fees to any patient referred.
- (6) The service registers with the Dental Board of California, providing its name and address.
- (7) The service files with the Dental Board of California a copy of the standard form contract that regulates its relationship with member dentists, which contract shall be confidential and not open to public inspection.
- (8) If more than 50 percent of its referrals are made to one individual, association, partnership, corporation, or group of three or more dentists, the service discloses that fact in all public communications, including, but not limited to, communication by means of television, radio, motion picture, newspaper, book, or list or directory of healing arts practitioners.
- (9) When member dentists pay any fee to the service, any advertisement by the service shall clearly and conspicuously disclose that fact by including a statement as follows: "Paid for by participating dentists." In print advertisements, the required statement shall be in at least 9-point type. In radio advertisements, the required statement shall be articulated so as to be clearly audible and understandable by the radio audience. In television advertisements, the required statement shall be either clearly audible and understandable to the television audience, or displayed in a written form that remains clearly visible for at least five seconds to the television audience. This subdivision shall be operative on and after July 1, 1994.

(b) The Dental Board of California may adopt regulations necessary to enforce and administer this section.

(c) The Dental Board of California may suspend or revoke the registration of any service that fails to comply with paragraph (9) of subdivision (a). No service may reregister with the board if it has a registration that is currently under suspension for a violation of paragraph (9) of subdivision (a), nor may a service reregister with the board if it had a registration revoked by the board for a violation of paragraph (9) of subdivision (a) less than one year after that revocation.

(d) The Dental Board of California may petition the superior court of any county for the issuance of an injunction restraining any conduct that constitutes a violation of this section.

(e) It is unlawful and shall constitute a misdemeanor for a person to operate a group advertising and referral service for dentists without providing its name and address to the Dental Board of California.

(f) It is the intent of the Legislature in enacting this section not to otherwise affect the prohibitions provided in Section 650. The Legislature intends to allow the pooling of resources by dentists for the purposes of advertising.

(g) This section shall not be construed to authorize a referral service to engage in the practice of dentistry.

(Amended by Stats. 2015, Ch. 426, Sec. 4. (SB 800) Effective January 1, 2016.)

650.3. (a) Notwithstanding the provisions of Section 650 or any other provision of law, it shall not be unlawful for a person licensed pursuant to the Chiropractic Act, or any other person, to participate in or operate a group advertising and referral service for chiropractors if all of the following conditions are met:

- (1) Patient referrals by the service are the result of patient initiated responses to service advertising.
- (2) The service advertises, if at all, in conformity with Section 651.

(3) The service does not employ a solicitor.

(4) The service does not impose a fee on the member chiropractors that is dependent upon the number of referrals or amount of professional fees paid by the patient to the chiropractor.

(5) Participating chiropractors charge no more than their usual and customary fees to any patient referred.

(6) The service registers with the State Board of Chiropractic Examiners, providing its name and address.

(7) The service files with the State Board of Chiropractic Examiners a copy of the standard form contract that regulates its relationship with member chiropractors, which contract shall be confidential and not open to public inspection.

(8) If more than 50 percent of its referrals are made to one individual, association, partnership, corporation, or group of three or more chiropractors, the service discloses that fact in all public communications, including, but not limited to, communication by means of television, radio, motion picture, newspaper, book, or list or directory of healing arts practitioners.

(b) The State Board of Chiropractic Examiners may adopt regulations necessary to enforce and administer this section.

(c) The State Board of Chiropractic Examiners or 10 individual licensed chiropractors may petition the superior court of any county for the issuance of an injunction restraining any conduct which constitutes a violation of this section.

(d) It is unlawful and shall constitute a misdemeanor for a person to operate a group advertising and referral service for chiropractors without providing its name and address to the State Board of Chiropractic Examiners.

(e) It is the intent of the Legislature in enacting this section not to otherwise affect the prohibitions provided in Section 650. The Legislature intends to allow the pooling of resources by chiropractors for the purpose of advertising.

(f) This section shall not be construed in any manner which would authorize a service to engage in the practice of chiropractic.

(Added by Stats. 1992, Ch. 856, Sec. 1. Effective January 1, 1993.)

651. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

(4) Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.

(7) Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.

(8) Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5) (A) A statement that the practitioner is certified by a private or public board or agency or a statement that the practitioner limits his or her practice to specific fields.

(B) A statement of certification by a practitioner licensed under Chapter 7 (commencing with Section 3000) shall only include a statement that he or she is certified or eligible for certification by a private or public board or parent association recognized by that practitioner's licensing board.

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician's and surgeon's licensing board prior to January 1, 2019, or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other

health care professionals that is based on the applicant's education, training, and experience. A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2019, shall retain that approval.

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician's and surgeon's licensing board prior to January 1, 2019, or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

(D) A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph, to be deposited in the State Treasury in the Podiatry Fund, pursuant to Section 2499. The fee shall not exceed the cost of administering this subparagraph.

(6) A statement that the practitioner provides services under a specified private or public insurance plan or health care plan.

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

(9) A statement of teaching positions currently or formerly held by the practitioner, together with pertinent dates.

(10) A statement of his or her affiliations with hospitals or clinics.

(11) A statement of the charges or fees for services or commodities offered by the practitioner.

(12) A statement that the practitioner regularly accepts installment payments of fees.

(13) Otherwise lawful images of a practitioner, his or her physical facilities, or of a commodity to be advertised.

(14) A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of commodities advertised.

(15) An advertisement of a registered dispensing optician may include statements in addition to those specified in paragraphs (1) to (14), inclusive, provided that any statement shall not violate subdivision (a), (b), (c), or (e) or any other section of this code.

(16) A statement, or statements, providing public health information encouraging preventive or corrective care.

(17) Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.

(i) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be

disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

(j) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

(k) A physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California or a doctor of podiatric medicine licensed pursuant to Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars (\$10,000) per event. Section 125.9 shall govern the issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

(Amended by Stats. 2017, Ch. 775, Sec. 6. (SB 798) Effective January 1, 2018.)

651.3. (a) Any labor organization, bona fide employee group or bona fide employee association having contracted health care services from a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (commencing with Section 1340 of the Health and Safety Code) may inform its members as to the benefits available and the charges therefor.

(b) Any new or revised written advertising or solicitation, or any form of evidence of coverage adopted by a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (commencing with Section 1340 of the Health and Safety Code) for distribution to members pursuant to subdivision (a) shall comply with the provisions of the Knox-Keene Health Care Service Plan Act of 1975 and the regulations thereunder.

(c) Any labor organization, bona fide employee group or bona fide employee association, contracting for a health care service plan under this section, shall not derive any profit from such plan.

Nothing contained in this section shall be construed as authorizing a provider of medical assistance, including a prepaid health plan, under the Medi-Cal Act or the Waxman-Duffy Prepaid Health Plan Act to advertise in violation of any of the provisions of such acts and regulations developed thereto.

(Amended by Stats. 1981, Ch. 662, Sec. 1.)

652. Violation of this article in the case of a licensed person constitutes unprofessional conduct and grounds for suspension or revocation of his or her license by the board by whom he or she is licensed, or if a license has been issued in connection with a place of business, then for the suspension or revocation of the place of business in connection with which the violation occurs. The proceedings for suspension or revocation shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and each board shall have all the powers granted therein. However, in the case of a licensee of the State Department of Health Services, the proceedings shall be conducted in accordance with Section 110171 of the Health and Safety Code. In addition, any violation constitutes a misdemeanor as to any and all persons offering, delivering, receiving, accepting, or participating in any rebate, refund, commission, preference, patronage dividend, unearned discount, or consideration, whether or not licensed under this division, and is punishable by imprisonment in the county jail not exceeding six months, by a fine not exceeding two thousand five hundred dollars (\$2,500), or by both the imprisonment and fine.

(Amended by Stats. 1997, Ch. 220, Sec. 3. Effective August 4, 1997.)

652.5. Except as otherwise provided in this article, any violation of this article constitutes a misdemeanor as to any and all persons, whether or not licensed under this division, and is punishable by imprisonment in the county jail not exceeding six months, or by a fine not exceeding two thousand five hundred dollars (\$2,500), or by both the imprisonment and fine.

(Amended by Stats. 1994, Ch. 1206, Sec. 6. Effective January 1, 1995.)

653. The word "person" as used in this article includes an individual, firm, partnership, association, corporation, limited liability company, or cooperative association.

(Amended by Stats. 1994, Ch. 1010, Sec. 3. Effective January 1, 1995.)

654. No person licensed under Chapter 5 (commencing with Section 2000) of this division may have any membership, proprietary interest or coownership in any form in or with any person licensed under Chapter 5.5 (commencing with Section 2550) of this

division to whom patients, clients or customers are referred or any profit-sharing arrangements.

(Amended by Stats. 1979, Ch. 688.)

654.1. Persons licensed under Chapter 4 (commencing with Section 1600) of this division or licensed under Chapter 5 (commencing with Section 2000) of this division or licensed under any initiative act referred to in this division relating to osteopaths may not refer patients, clients, or customers to any clinical laboratory licensed under Section 1265 in which the licensee has any membership, proprietary interest, or coownership in any form, or has any profit-sharing arrangement, unless the licensee at the time of making such referral discloses in writing such interest to the patient, client, or customer. The written disclosure shall indicate that the patient may choose any clinical laboratory for purposes of having any laboratory work or assignment performed.

This section shall not apply to persons who are members of a medical group which contracts to provide medical care to members of a group practice prepayment plan registered under the Knox-Keene Health Care Service Act of 1975, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

This section shall not apply to any referral to a clinical laboratory which is owned and operated by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

This section does not prohibit the acceptance of evaluation specimens for proficiency testing or referral of specimens or such assignment from one clinical laboratory to another clinical laboratory, either licensed or exempt under this chapter, providing the report indicates clearly the laboratory performing the test.

"Proprietary interest" does not include ownership of a building where space is leased to a clinical laboratory at the prevailing rate under a straight lease arrangement.

A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding ten thousand dollars (\$10,000), or by both that imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code.

(Amended by Stats. 2011, Ch. 15, Sec. 4. (AB 109) Effective April 4, 2011. Operative October 1, 2011, by Sec. 636 of Ch. 15, as amended by Stats. 2011, Ch. 39, Sec. 68.)

654.2. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to charge, bill, or otherwise solicit payment from a patient on behalf of, or refer a patient to, an organization in which the licensee, or the licensee's immediate family, has a significant beneficial interest, unless the licensee first discloses in writing to the patient, that there is such an interest and advises the patient that the patient may choose any organization for the purpose of obtaining the services ordered or requested by the licensee.

(b) The disclosure requirements of subdivision (a) may be met by posting a conspicuous sign in an area which is likely to be seen by all patients who use the facility or by providing those patients with a written disclosure statement. Where referrals, billings, or other solicitations are between licensees who contract with multispecialty clinics pursuant to subdivision (l) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of subdivision (a) may be met by posting a conspicuous disclosure statement at a single location which is a common area or registration area or by providing those patients with a written disclosure statement.

(c) On and after July 1, 1987, persons licensed under this division or under any initiative act referred to in this division shall disclose in writing to any third-party payer for the patient, when requested by the payer, organizations in which the licensee, or any member of the licensee's immediate family, has a significant beneficial interest and to which patients are referred. The third-party payer shall not request this information from the provider more than once a year.

Nothing in this section shall be construed to serve as the sole basis for the denial or delay of payment of claims by third party payers.

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Immediate family" includes the spouse and children of the licensee, the parents of the licensee and licensee's spouse, and the spouses of the children of the licensee.

(2) "Significant beneficial interest" means any financial interest that is equal to or greater than the lesser of the following:

(A) Five percent of the whole.

(B) Five thousand dollars (\$5,000).

(3) A third-party payer includes any health care service plan, self-insured employee welfare benefit plan, disability insurer, nonprofit hospital service plan, or private group or indemnification insurance program.

A third party payer does not include a prepaid capitated plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 or Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(e) This section shall not apply to a "significant beneficial interest" which is limited to ownership of a building where the space is leased to the organization at the prevailing rate under a straight lease agreement or to any interest held in publicly traded stocks.

(f) (1) This section does not prohibit the acceptance of evaluation specimens for proficiency testing or referral of specimens or assignment from one clinical laboratory to another clinical laboratory, either licensed or exempt under this chapter, if the report indicates clearly the name of the laboratory performing the test.

(2) This section shall not apply to relationships governed by other provisions of this article nor is this section to be construed as permitting relationships or interests that are prohibited by existing law on the effective date of this section.

(3) The disclosure requirements of this section shall not be required to be given to any patient, customer, or his or her representative, if the licensee, organization, or entity is providing or arranging for health care services pursuant to a prepaid capitated contract with the State Department of Health Services.

(Amended by Stats. 1986, Ch. 881, Sec. 1.)

654.3. (a) For purposes of this section, the following definitions shall apply:

(1) "Arrange for" and "establish" mean the act of a licensee, or an employee or agent of that licensee, receiving application information from the applicant and submitting it to the lender for approval or rejection.

(2) "Deferred interest provision" means a contractual provision that allows for interest to be charged on portions of the original balance that have already been paid off.

(3) "Licensee" means an individual, firm, partnership, association, corporation, limited liability company, or cooperative association licensed under this division or under any initiative act or division referred to in this division.

(4) "Licensee's office" means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with law. Employees and independent contractors shall be licensed or certified when licensure or certification is required by law.

(5) "Open-end credit" means credit extended by a creditor under a plan in which the creditor reasonably contemplates repeated transactions, the creditor may impose a finance charge from time to time on an outstanding unpaid balance, and the amount of credit that may be extended to the debtor during the term of the plan, up to any limit set by the creditor, is generally made available to the extent that any outstanding balance is repaid.

(6) (A) "Patient" includes, but is not limited to, the patient's parent or other legal representative.

(B) In veterinary medical settings, "patient" means one of the following, as indicated by context:

(i) If the patient is receiving the services, the owned animal of a client.

(ii) If the patient is agreeing to or paying for services, the client owner of an animal patient.

(b) (1) It is unlawful for a licensee, or employee or agent of that licensee, to arrange for or establish an open-end credit or loan that contains a deferred interest provision.

(2) This subdivision shall not be construed as prohibiting a licensee, or employee or agent of a licensee, from doing any of the following:

(A) Charging treatment or costs to an open-end credit or loan that is lawfully extended by a third party, including those that contain deferred interest provisions.

(B) Arranging for or establishing an open-end credit or loan that does any of the following:

(i) Offers a promotional period during which a debtor may avoid the payment of interest in connection with an open-end credit plan.

(ii) At the end of a promotional period, charges interest on any unpaid balance remaining at that time.

(iii) Imposes a late fee on a debtor who fails to pay the minimum amount due during any payment period.

(c) (1) It is unlawful for a licensee, or employee or agent of that licensee, to charge treatment or costs to an open-end credit or loan, that is extended by a third party and that is arranged for, or established in, that licensee's office, more than 30 days before the date upon which the treatment is rendered or costs are incurred.

(2) This subdivision does not apply to orthodontic treatment provided by a licensed dentist who may charge incremental fees throughout the course of treatment.

(d) It is unlawful for a licensee, or employee or agent of that licensee, to charge treatment or costs to an open-end credit or loan that is extended by a third party and that is arranged for, or established in, that licensee's office without first providing the patient with a treatment plan, as required by subdivision (h), and a list of which treatment and services are being charged in advance of rendering treatment or incurring costs.

(e) It is unlawful for a licensee, or employee or agent of a licensee, to complete any portion of an application for credit or a loan extended by a third party for the patient or otherwise arrange for or establish an application that is not completely filled out by the patient.

(f) A licensee shall, within 15 business days of a patient's request, refund to the lender any payment received through credit or a loan extended by a third party that is arranged for, or established in, that licensee's office for treatment that has not been rendered or costs that have not been incurred.

(g) A licensee, or an employee or agent of that licensee, shall not arrange for or establish credit or a loan extended by a third party for a patient without first providing the following written or electronic notice, on one page or screen, respectively, in at least 14-point type, and obtaining a signature from the patient:

"Credit or Loan for Health Care Services

The attached application and information is for a credit card or loan to help you pay for your health care treatment. You should know that:

You are applying for a ____ credit card or a ____ loan for \$ ____.

You do not have to apply for the credit card or the loan. You may request a different place and additional time to review, fill out, and sign the application. You may pay your health care provider for treatment in another manner.

This credit card or loan is not a payment plan with the provider's office. It is credit with, or a loan made by, [name of company issuing the credit card or loan]. Your health care provider does not work for this company.

Before applying for this credit card or loan, you have the right to a written treatment plan from your health care provider. This plan must include the expected treatment to be provided and the estimated costs of each service. If you have insurance, the treatment plan must tell you how much your insurance is expected to cover. If you are a Medi-Cal patient seeking services from a Medi-Cal provider, your treatment plan must tell you if Medi-Cal will cover a different service to treat your condition. If you only want services covered by Medi-Cal, you should not sign up for this credit card or loan.

Your health care provider cannot charge your credit card or loan account before you start treatment.

You have the right to have your credit card or loan account refunded for any charges for treatment you did not get. However, your provider does not have to refund the amount they spent to prepare for your treatment. Your health care provider must refund the amount of the charges to the lender within 15 business days of your request. The lender must take refunded charges off your account.

Please read carefully the terms and conditions of this credit card or loan.

You may be required to pay interest rates on the amount charged to the credit card or the amount of the loan. If you pay late, you may have to pay a penalty and a higher interest rate.

You may use this credit card or loan to pay for future health care services.

If you do not pay the money that you owe on the credit card or loan, your missed payments can be reported and could hurt your credit rating. You could also be sued.

[Patient's Signature]"

(h) Before arranging for or establishing credit or a loan extended by a third party, a licensee shall give a patient a written treatment plan that complies with all of the following:

(1) The treatment plan shall include each anticipated service to be provided and the estimated cost of each service.

(2) If a patient is covered by a private or government medical benefit plan or medical insurance from which the licensee takes assignment of benefits, the treatment plan shall indicate the patient's private or government-estimated share of cost for each service.

(3) If the licensee accepts Medi-Cal, the treatment plan for a Medi-Cal patient shall indicate if Medi-Cal would cover an alternate, medically necessary service as defined in Section 14059.5 of the Welfare and Institutions Code. The treatment plan shall indicate that the Medi-Cal patient has a right to ask for only services covered by Medi-Cal and that the licensee agrees to follow Medi-Cal rules to secure Medi-Cal covered services before treatment.

(4) If the licensee does not take assignment of benefits from a patient's medical benefit plan or insurance, the treatment plan shall indicate that the treatment may or may not be covered by a patient's medical benefit or insurance plan, and that the patient has the right to confirm medical benefit or insurance information from the patient's plan, insurer, or employer before beginning treatment.

(i) A licensee, or an employee or agent of that licensee, shall not arrange for or establish credit or a loan extended by a third party for a patient with whom the licensee, or an employee or agent of that licensee, communicates primarily in a language other than English that is one of the Medi-Cal threshold languages, unless the written notice information required by subdivision (g) is also provided in that language.

(j) (1) A licensee, or an employee or agent of that licensee, shall not arrange for or establish credit or a loan that is extended by a third party for a patient under either of the following circumstances:

(A) The patient has been administered or is under the influence of general anesthesia, conscious sedation, or nitrous oxide.

(B) The patient is in a treatment area, including, but not limited to, an exam room, surgical room, or other area where medical treatment is administered, unless the patient agrees to fill out and sign the application to arrange for or establish credit or a loan in the treatment area.

(2) Paragraph (1) shall not apply to veterinary medicine. Any credit or loan application offered to an owner of an animal shall be filled out by the owner.

(k) A patient who suffers any damage as a result of the use or employment by any person of a method, act, or practice that willfully violates this section may seek the relief provided by Chapter 4 (commencing with Section 1780) of Title 1.5 of Part 4 of Division 3 of the Civil Code.

(l) The rights, remedies, and penalties set forth in this article are cumulative, and shall not supersede the rights, remedies, or penalties established under other laws.

(m) This section shall become operative on July 1, 2020.

(Repealed (in Sec. 1) and added by Stats. 2019, Ch. 856, Sec. 2. (SB 639) Effective January 1, 2020. Section operative July 1, 2020, by its own provisions.)

655. (a) For the purposes of this section, the following terms have the following meanings:

(1) "Health plan" means a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(2) "Optical company" means a person or entity that is engaged in the manufacture, sale, or distribution to physicians and surgeons, optometrists, health plans, or dispensing opticians of lenses, frames, optical supplies, or optometric appliances or devices or kindred products.

(3) "Optometrist" means a person licensed pursuant to Chapter 7 (commencing with Section 3000) or an optometric corporation, as described in Section 3160.

(4) "Physician and surgeon" means a person licensed by the Medical Board of California or the Osteopathic Medical Board of California under Chapter 5 (commencing with Section 2000) or a medical corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code.

(5) "Registered dispensing optician" means a person or entity licensed pursuant to Chapter 5.5 (commencing with Section 2550).

(6) "Therapeutic ophthalmic product" means lenses or other products that provide direct treatment of eye disease or visual rehabilitation for diseased eyes.

(b) No optometrist may have any membership, proprietary interest, coownership, or any profit-sharing arrangement, either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with any registered dispensing optician or any optical company, except as otherwise permitted under this section.

(c) (1) A registered dispensing optician or an optical company may operate, own, or have an ownership interest in a health plan so long as the health plan does not directly employ optometrists to provide optometric services directly to enrollees of the health plan, and may directly or indirectly provide products and services to the health plan or its contracted providers or enrollees or to other optometrists. For purposes of this section, an optometrist may be employed by a health plan as a clinical director for the health plan pursuant to Section 1367.01 of the Health and Safety Code or to perform services related to utilization management or quality assurance or other similar related services that do not require the optometrist to directly provide health care services to enrollees. In addition, an optometrist serving as a clinical director may not employ optometrists to provide health care services to enrollees of the health plan for which the optometrist is serving as clinical director. For the purposes of this section, the health plan's utilization management and quality assurance programs that are consistent with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) do not constitute providing health care services to enrollees.

(2) The registered dispensing optician or optical company shall not interfere with the professional judgment of the optometrist.

(3) The Department of Managed Health Care shall forward to the California State Board of Optometry any complaints received from consumers that allege that an optometrist violated the Optometry Practice Act (Chapter 7 (commencing with Section 3000)). The Department of Managed Health Care and the California State Board of Optometry shall enter into an Inter-Agency Agreement regarding the sharing of information related to the services provided by an optometrist that may be in violation of the Optometry Practice Act that the Department of Managed Health Care encounters in the course of the administration of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) An optometrist, a registered dispensing optician, a physician and surgeon, an optical company, or a health plan may execute a lease, sublease, or other written agreement with an optometrist, if all of the following conditions are contained in a written agreement establishing the landlord-tenant relationship:

(1) (A) The practice shall be owned by the optometrist and in every phase be under the optometrist's exclusive control, including the selection and supervision of optometric staff, the scheduling of patients, the amount of time the optometrist spends with patients, fees charged for optometric products and services, the examination procedures and treatment provided to patients, and the optometrist's contracting with managed care organizations.

(B) Subparagraph (A) shall not preclude a lease from including commercially reasonable terms that: (i) require the provision of optometric services at the leased space during certain days and hours, (ii) restrict the leased space from being used for the sale or offer for sale of spectacles, frames, lenses, contact lenses, or other ophthalmic products, except that the optometrist shall be permitted to sell therapeutic ophthalmic products if the registered dispensing optician, physician and surgeon, health plan, or optical company located on or adjacent to the optometrist's leased space does not offer any substantially similar therapeutic ophthalmic products for sale, (iii) require the optometrist to contract with a health plan network, health plan, or health insurer, or (iv) permit the landlord to directly or indirectly provide furnishings and equipment in the leased space.

(2) The optometrist's records shall be the sole property of the optometrist. Only the optometrist and those persons with written authorization from the optometrist shall have access to the patient records and the examination room, except as otherwise provided by law.

(3) The optometrist's leased space shall be definite and distinct from space occupied by other occupants of the premises, have a sign designating that the leased space is occupied by an independent optometrist or optometrists and be accessible to the optometrist after hours or in the case of an emergency, subject to the facility's general accessibility. This paragraph shall not require a separate entrance to the optometrist's leased space.

(4) All signs and displays shall be separate and distinct from that of the other occupants and shall have the optometrist's name and the word "optometrist" prominently displayed in connection therewith. This paragraph shall not prohibit the optometrist from advertising the optometrist's practice location with reference to other occupants or prohibit the optometrist or registered dispensing optician from advertising their participation in any health plan's network or the health plan's products in which the optometrist or registered dispensing optician participates.

(5) There shall be no signs displayed on any part of the premises or in any advertising indicating that the optometrist is employed or controlled by the registered dispensing optician, health plan, or optical company.

(6) Except for a statement that an independent doctor of optometry is located in the leased space, in-store pricing signs and as otherwise permitted by this subdivision, the registered dispensing optician or optical company shall not link its advertising with the optometrist's name, practice, or fees.

(7) Notwithstanding paragraphs (4) and (6), this subdivision shall not preclude a health plan from advertising its health plan products and associated premium costs and any copayments, coinsurance, deductibles, or other forms of cost sharing, or the names and locations of the health plan's providers, including any optometrists or registered dispensing opticians that provide professional services, in compliance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(8) A health plan that advertises its products and services in accordance with paragraph (7) shall not advertise the optometrist's fees for products and services that are not included in the health plan's contract with the optometrist.

(9) The optometrist shall not be precluded from collecting fees for services that are not included in a health plan's products and services, subject to any patient disclosure requirements contained in the health plan's provider agreement with the optometrist or that are not otherwise prohibited by the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(10) The term of the lease shall be no less than one year and shall not require the optometrist to contract exclusively with a health plan. The optometrist may terminate the lease according to the terms of the lease. The landlord may terminate the lease for the following reasons:

(A) The optometrist's failure to maintain a license to practice optometry or the imposition of restrictions, suspension or revocation of the optometrist's license, or if the optometrist or the optometrist's employee is or becomes ineligible to participate in state or federal government-funded programs.

(B) Termination of any underlying lease where the optometrist has subleased space, or the optometrist's failure to comply with the underlying lease provisions that are made applicable to the optometrist.

(C) If the health plan is the landlord, the termination of the provider agreement between the health plan and the optometrist, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(D) Other reasons pursuant to the terms of the lease or permitted under the Civil Code.

(11) The landlord shall act in good faith in terminating the lease and in no case shall the landlord terminate the lease for reasons that constitute interference with the practice of optometry.

(12) Lease or rent terms and payments shall not be based on number of eye exams performed, prescriptions written, patient referrals, or the sale or promotion of the products of a registered dispensing optician or an optical company.

(13) The landlord shall not terminate the lease solely because of a report, complaint, or allegation filed by the optometrist against the landlord, a registered dispensing optician, or a health plan, to the California State Board of Optometry or the Department of Managed Health Care or any law enforcement or regulatory agency.

(14) The landlord shall provide the optometrist with written notice of the scheduled expiration date of a lease at least 60 days prior to the scheduled expiration date. This notice obligation shall not affect the ability of either party to terminate the lease pursuant to this section. The landlord may not interfere with an outgoing optometrist's efforts to inform the optometrist's patients, in accordance with customary practice and professional obligations, of the relocation of the optometrist's practice.

(15) The California State Board of Optometry may inspect, upon request, an individual lease agreement pursuant to its investigational authority, and if such a request is made, the landlord or tenant, as applicable, shall promptly comply with the request. Failure or refusal to comply with the request for lease agreements within 30 days of receiving the request constitutes unprofessional conduct and is grounds for disciplinary action by the appropriate regulatory agency. This section shall not affect the Department of Managed Health Care's authority to inspect all books and records of a health plan pursuant to Section 1381 of the Health and Safety Code.

Any financial information contained in the lease submitted to a regulatory entity, pursuant to this paragraph, shall be considered confidential trade secret information that is exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(16) This subdivision shall not be applicable to the relationship between any optometrist employee and the employer medical group, or the relationship between a medical group exclusively contracted with a health plan regulated by the Department of Managed Health Care and that health plan.

(e) No registered dispensing optician may have any membership, proprietary interest, coownership, or profit-sharing arrangement either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with an optometrist, except as permitted under this section.

(f) Nothing in this section shall prohibit a person licensed under Chapter 5 (commencing with Section 2000) or its professional corporation from contracting with or employing optometrists, ophthalmologists, or optometric assistants and entering into a contract or landlord-tenant relationship with a health plan, an optical company, or a registered dispensing optician, in accordance with Sections 650 and 654 of this code.

(g) Any violation of this section constitutes a misdemeanor as to such person licensed under Chapter 7 (commencing with Section 3000) of this division and as to any and all persons, whether or not so licensed under this division, who participate with such licensed person in a violation of any provision of this section.

(h) (1) Notwithstanding any other law and in addition to any action available to the California State Board of Optometry, the California State Board of Optometry may issue a citation containing an order of abatement, an order to pay an administrative fine, or both, to an optical company, an optometrist, or a registered dispensing optician for a violation of this section. The administrative fine shall not exceed fifty thousand dollars (\$50,000) per administrative action. Notwithstanding any other law and in addition to any action available to the Medical Board of California or the Osteopathic Medical Board of California, the Medical Board of California or the Osteopathic Medical Board of California may issue a citation containing an order of abatement, an order to pay an administrative fine, or both, to a physician and surgeon for a violation of this section. In assessing the amount of the fine, the board shall give due consideration to all of the following:

(A) The gravity of the violation.

(B) The good faith of the cited person or entity.

(C) The history of previous violations of the same or similar nature.

(D) Evidence that the violation was or was not willful.

(E) The extent to which the cited person or entity has cooperated with the board's investigation.

(F) The extent to which the cited person or entity has mitigated or attempted to mitigate any damage or injury caused by the violation.

(G) Any other factors as justice may require.

(2) A citation or fine assessment issued pursuant to a citation shall inform the cited person or entity that if a hearing is desired to contest the finding of a violation, that hearing shall be requested by written notice to the board within 30 days of the date of issuance of the citation or assessment. If a hearing is not requested pursuant to this section, payment of any fine shall not constitute an admission of the violation charged. Hearings shall be held pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(3) The board shall adopt regulations to implement a system for the issuance of citations, administrative fines, and orders of abatement authorized by this section. The regulations shall include provisions for both of the following:

(A) The issuance of a citation without an administrative fine.

(B) The opportunity for a cited person or entity to have an informal conference with the executive officer of the board in addition to the hearing described in paragraph (2).

(4) The failure of a licensee to pay a fine within 30 days of the date of assessment, unless the citation is being appealed, may result in disciplinary action being taken by the board. Where a citation is not contested and a fine is not paid, the full amount of the assessed fine shall be added to the fee for renewal of the license. A license shall not be renewed without payment of the renewal fee and fine.

(5) Notwithstanding any other law, if a fine is paid to satisfy an assessment based on the finding of a violation, payment of the fine shall be represented as satisfactory resolution of the matter for purposes of public disclosure.

(i) Administrative fines collected pursuant to this section shall be deposited in the fund of the board that has issued the fine. It is the intent of the Legislature that moneys collected as fines and deposited in the fund be used by the board primarily for enforcement purposes.

(j) Any complaints against a physician and surgeon for violations of this section shall be referred to the physician and surgeon's licensing board.

(k) This section shall become operative on January 1, 2023.

(Amended (as added by Stats. 2021, Ch. 630, Sec. 11) by Stats. 2022, Ch. 28, Sec. 2. (SB 1380) Effective January 1, 2023.)

655.2. (a) (1) No physician and surgeon or medical corporation licensed under Chapter 5 (commencing with Section 2000), nor any audiologist who is not a licensed dispensing audiologist or hearing aid dispenser shall employ any individual licensed pursuant to

Article 8 (commencing with Section 2538.10) of Chapter 5.3 for the purpose of fitting or selling hearing aids.

(2) No individual licensed pursuant to Article 8 (commencing with Section 2538.10) of Chapter 5.3 shall employ any physician and surgeon or any audiologist who is not a licensed dispensing audiologist or hearing aid dispenser, or contract with a medical corporation licensed under Chapter 5 (commencing with Section 2000), for the purpose of fitting or selling hearing aids.

(b) This section shall not apply to any physician and surgeon or medical corporation that contracts with or is affiliated with a comprehensive group practice health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, as set forth in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(Amended by Stats. 2014, Ch. 316, Sec. 2. (SB 1466) Effective January 1, 2015.)

655.5. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division, or any clinical laboratory, or any health facility when billing for a clinical laboratory of the facility, to charge, bill, or otherwise solicit payment from any patient, client, or customer for any clinical laboratory service not actually rendered by the person or clinical laboratory or under his, her or its direct supervision unless the patient, client, or customer is apprised at the first time of the charge, billing, or solicitation of the name, address, and charges of the clinical laboratory performing the service. The first such written charge, bill, or other solicitation of payment shall separately set forth the name, address, and charges of the clinical laboratory concerned and shall clearly show whether or not the charge is included in the total of the account, bill, or charge. This subdivision shall be satisfied if the required disclosures are made to the third-party payer of the patient, client, or customer. If the patient is responsible for submitting the bill for the charges to the third-party payer, the bill provided to the patient for that purpose shall include the disclosures required by this section. This subdivision shall not apply to a clinical laboratory of a health facility or a health facility when billing for a clinical laboratory of the facility nor to a person licensed under this division or under any initiative act referred to in this division if the standardized billing form used by the facility or person requires a summary entry for all clinical laboratory charges. For purposes of this subdivision, "health facility" has the same meaning as defined in Section 1250 of the Health and Safety Code.

(b) Commencing July 1, 1994, a clinical laboratory shall provide to each of its referring providers, upon request, a schedule of fees for services provided to patients of the referring provider. The schedule shall be provided within two working days after the clinical laboratory receives the request. For the purposes of this subdivision, a "referring provider" means any provider who has referred a patient to the clinical laboratory in the preceding six-month period. Commencing July 1, 1994, a clinical laboratory that provides a list of laboratory services to a referring provider or to a potential referring provider shall include a schedule of fees for the laboratory services listed.

(c) It is also unlawful for any person licensed under this division or under any initiative act referred to in this division to charge additional charges for any clinical laboratory service that is not actually rendered by the licensee to the patient and itemized in the charge, bill, or other solicitation of payment. This section shall not be construed to prohibit any of the following:

(1) Any itemized charge for any service actually rendered to the patient by the licensee.

(2) Any summary charge for services actually rendered to a patient by a health facility, as defined in Section 1250 of the Health and Safety Code, or by a person licensed under this division or under any initiative act referred to in this division if the standardized billing form used by the facility or person requires a summary entry for all clinical laboratory charges.

(d) As used in this section, the term "any person licensed under this division" includes a person licensed under paragraph (1) of subdivision (a) of Section 1265, all wholly owned subsidiaries of the person, a parent company that wholly owns the person, and any subsidiaries wholly owned by the same parent that wholly owns the person. "Wholly owned" means ownership directly or through one or more subsidiaries. This section shall not apply to billings by a person licensed under paragraph (1) of subdivision (a) of Section 1265 when the person licensed under paragraph (1) of subdivision (a) of Section 1265 bills for services performed by any laboratory owned or operated by the person licensed under paragraph (1) of subdivision (a) of Section 1265.

(e) This section shall not apply to any person or clinical laboratory who or which contracts directly with a health care service plan licensed pursuant to Section 1349 of the Health and Safety Code, if the services are to be provided to members of the plan on a prepaid basis and without additional charge or liability on account thereof.

(f) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding ten thousand dollars (\$10,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code.

(g) (1) Notwithstanding subdivision (f), a violation of this section by a physician and surgeon for a first offense shall be subject to the exclusive remedy of reprimand by the Medical Board of California if the transaction that is the subject of the violation involves a charge for a clinical laboratory service that is less than the charge would have been if the clinical laboratory providing the service billed a patient, client, or customer directly for the clinical laboratory service, and if that clinical laboratory charge is less than the charge listed in the clinical laboratory's schedule of fees pursuant to subdivision (b).

(2) Nothing in this subdivision shall be construed to permit a physician and surgeon to charge more than he or she was charged for the laboratory service by the clinical laboratory providing the service unless the additional charge is for service actually rendered by the physician and surgeon to the patient.

(Amended by Stats. 2011, Ch. 15, Sec. 5. (AB 109) Effective April 4, 2011. Operative October 1, 2011, by Sec. 636 of Ch. 15, as amended by Stats. 2011, Ch. 39, Sec. 68.)

655.7. (a) (1) A person licensed under this division or under an initiative act referred to in this division shall not charge, bill, or otherwise solicit payment, directly or indirectly, for anatomic pathology services if those services were not actually rendered by that person or under his or her direct supervision.

(2) Notwithstanding paragraph (1), a clinical laboratory may seek payment for anatomic pathology services provided directly or through arrangements with a physician and surgeon in compliance with Article 18 (commencing with Section 2400) of Chapter 5 or if it is required to send a sample to another clinical laboratory for specialized testing or services and if that clinical laboratory has performed the services, directly or through arrangements with a physician and surgeon as set forth in this subdivision, described in subdivision (e) related to that sample.

(3) Notwithstanding paragraph (1), a clinical laboratory may bill for anatomic pathology services that were performed by an affiliated clinical laboratory. For purposes of this section, an "affiliated clinical laboratory" means a clinical laboratory that is wholly owned by, is the parent company of, or is under common ownership with, the clinical laboratory billing for the anatomic pathology services. For purposes of this section, "wholly owned" means 100 percent ownership directly or through one or more subsidiaries, and "common ownership" means 100 percent ownership by a common parent company.

(b) A clinical laboratory or a physician and surgeon performing anatomic pathology services shall seek payment for those services solely from the following:

(1) The patient.

(2) The insurer, health care service plan, or other third-party payer responsible for payment of the services.

(3) The hospital, public health clinic, or nonprofit health clinic ordering the services.

(4) The clinical laboratory that sent the sample for specialized testing or services only if that clinical laboratory has performed the services, directly or through arrangements with a physician and surgeon in compliance with Article 18 (commencing with Section 2400) of Chapter 5, described in subdivision (e) related to that sample.

(5) A governmental agency or its specified public or private agent, agency, or organization responsible for payment of the services.

(c) No person is required to reimburse a person licensed under this division or under an initiative act referred to in this division for a charge or claim made in violation of this section.

(d) This section shall not apply to any of the following:

(1) A person who, or a clinical laboratory that, contracts directly with a health care service plan licensed pursuant to Section 1349 of the Health and Safety Code, if services are to be provided to enrollees of the plan on a prepaid basis.

(2) A person who, or a clinic that, provides anatomic pathology services without charge to the patient, or on a sliding scale payment basis if the patient's charge for services is determined by the patient's ability to pay.

(3) Health care programs operated by public entities, including, but not limited to, colleges and universities.

(4) Health care programs operated by private educational institutions to serve the health care needs of their students.

(5) A person who, or a clinic that, contracts with an employer to provide medical services to its employees if the anatomic pathology services relating to the examination of gynecologic slides are provided under the contract.

(e) For the purposes of this section, the term "anatomic pathology services" means any of the following:

(1) Histopathology, meaning the gross and microscopic examination of organ tissue performed by a physician and surgeon or under the supervision of a physician and surgeon.

(2) Cytopathology, meaning the examination of cells from fluids, aspirates, washings, brushings, or smears, including the Pap test examination, performed by a physician and surgeon or under the supervision of a physician and surgeon.

(3) Hematology, meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician and surgeon, or under the supervision of a physician and surgeon, and peripheral blood smears when the attending or treating physician and surgeon or technologist requests that a blood smear be reviewed by a pathologist.

(4) Subcellular pathology and molecular pathology, when required to be reviewed by a pathologist.

(5) Surgical pathology, meaning the gross and microscopic examination of organ tissue performed by a physician and surgeon or under the supervision of a physician and surgeon.

(6) Transfusion medicine or blood banking services performed by a pathologist.

(Added by Stats. 2007, Ch. 656, Sec. 2. Effective January 1, 2008.)

655.8. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to charge, bill, or otherwise solicit payment from any patient, client, customer, or third-party payer for performance of the technical component of Computerized Tomography (CT), Positron Emission Tomography (PET), or Magnetic Resonance Imaging (MRI) diagnostic imaging services if those services were not actually rendered by the licensee or a person under his or her supervision.

(b) Radiological facilities or imaging centers performing the technical component of CT, PET, or MRI diagnostic imaging services shall directly bill either the patient or the responsible third-party payer for such services rendered by those facilities. Radiological facilities or imaging centers shall not bill the licensee who requests the services.

(c) This section shall not apply to any of the following:

(1) Any person who, or radiological facility or imaging center that, contracts directly with a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(2) Any person who, or clinic that, provides diagnostic imaging services without charge to the patient, or on a sliding scale payment basis if the patient's charge for services is determined by the patient's ability to pay.

(3) Health care programs operated by public entities, including, but not limited to, colleges and universities.

(4) Health care programs operated by private educational institutions to serve the health care needs of their students.

(5) Any person who, or clinic that, contracts with an employer to provide medical services to employees of the employer if the diagnostic imaging services are provided under the contract.

(6) Diagnostic imaging services that are performed within a physician and surgeon's office, as defined in paragraph (5) of subdivision (b) of Section 650.01, or the office of a group practice, as defined in paragraph (6) of subdivision (b) of Section 650.01.

(d) Nothing in this section prohibits a licensee or a physician entity from billing globally for professional and technical components if both of the following conditions are met:

(1) Neither the physician, or any member of his or her medical group, nor the physician entity has ordered the diagnostic imaging services.

(2) The physician, or a member of his or her medical group, or the physician entity provides the professional interpretation of the diagnostic imaging service.

(e) Nothing in subdivision (d) is intended to authorize or permit an imaging center to engage in the practice of medicine or exercise other professional rights, privileges, or powers in violation of Section 2400 of the Business and Professions Code.

(f) For the purposes of this section, the following terms shall have the following meanings:

(1) "Physician entity" means a professional medical corporation formed pursuant to Section 2406 or a general partnership that consists entirely of physicians and surgeons or professional medical corporations.

(2) "Responsible third-party payer" means any person or entity who is responsible to pay for CT, PET, or MRI services provided to a patient.

(3) "Supervision" means that the referring licensee is providing the level of supervision set forth in paragraph (3) of subsection (b) of Section 410.32 of Title 42 of the Code of Federal Regulations.

(4) "Technical component" includes services other than those provided by a physician and surgeon for the CT, PET, or MRI including personnel, materials, space, equipment, and other facilities.

(Added by Stats. 2008, Ch. 469, Sec. 1. Effective January 1, 2009.)

656. Whenever any person has engaged, or is about to engage, in any acts or practices that constitute, or will constitute, a violation of this article, the superior court in and for the county wherein the acts or practices take place, or are about to take place, may issue an injunction, or other appropriate order, restraining the conduct on application of the California State Board of Optometry, the Medical Board of California, the California Board of Podiatric Medicine, the Osteopathic Medical Board of California, the Attorney General, or the district attorney of the county.

The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.

The remedy provided for in this section shall be in addition to, and not a limitation upon, the authority provided by any other provision of this code.

(Amended by Stats. 2021, Ch. 630, Sec. 12. (AB 1534) Effective January 1, 2022.)

657. (a) The Legislature finds and declares all of the following:

(1) Californians spend more than one hundred billion dollars (\$100,000,000,000) annually on health care.

(2) In 1994, an estimated 6.6 million of California's 32 million residents did not have any health insurance and were ineligible for Medi-Cal.

(3) Many of California's uninsured cannot afford basic, preventative health care resulting in these residents relying on emergency rooms for urgent health care, thus driving up health care costs.

(4) Health care should be affordable and accessible to all Californians.

(5) The public interest dictates that uninsured Californians have access to basic, preventative health care at affordable prices.

(b) To encourage the prompt payment of health or medical care claims, health care providers are hereby expressly authorized to grant discounts in health or medical care claims when payment is made promptly within time limits prescribed by the health care providers or institutions rendering the service or treatment.

(c) Notwithstanding any provision in any health care service plan contract or insurance contract to the contrary, health care providers are hereby expressly authorized to grant discounts for health or medical care provided to any patient the health care provider has reasonable cause to believe is not eligible for, or is not entitled to, insurance reimbursement, coverage under the Medi-Cal program, or coverage by a health care service plan for the health or medical care provided. Any discounted fee granted pursuant to this section shall not be deemed to be the health care provider's usual, customary, or reasonable fee for any other purposes, including, but not limited to, any health care service plan contract or insurance contract.

(d) "Health care provider," as used in this section, means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(Amended by Stats. 1998, Ch. 20, Sec. 1. Effective April 14, 1998.)