THE CENTER FOR CHOLESTEROL MANAGEMENT
A Medical Corporation
1950 Sawtelle Blvd, Suite 150
Los Angeles, CA 90025

******Please complete all pages of this form******

NAME: _____DATE: _____

SEX: ___M ___F DOB: ___/___/____ SSN: _____ DL#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAX: _____EMAIL: _____PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____PHONE: _____

ADDRESS:_____ CITY :_____ STATE: _____ ZIP: _____

Please list all of your medications, include non-prescription drugs, dietary supplements, and vitamins.

NAME OF DRUG: DOSE: No. TIMES DAILY:

_____

_____

_____

_____

Have you ever been diagnosed with?

High Blood Pressure ☐ **Yes** ☐ **No** **How long ago? _____**

Diabetes ☐ **Yes** ☐ **No** **How long ago? _____**

Stroke ☐ **Yes** ☐ **No** **When did it occur? _____**

High Cholesterol ☐ **Yes** ☐ **No** **What medications do you take for this, if any? _____**

Lung Disease ☐ **Yes** ☐ **No** **What type? _____**

Heart Disease ☐ **Yes** ☐ **No** **How long ago?** _____

Other Vascular Disease ☐ **Yes** ☐ **No** **How long ago?** _____

List other medical problems you have had. These would include problems for which you have taken medications or been hospitalized. Please include the dates these problems occurred.

_____

_____

_____

_____

Are you allergic to any medications? ☐ **Yes** ☐ **No**

List those medications? _____

Are you allergic to X-Ray dye? ☐ **Yes** ☐ **No**

List all surgeries, both major and minor, you have had:

SURGERY **DATE** **HOSPITAL**

_____

_____

_____

Have you ever smoked? ☐ **Yes** ☐ **No** **How many cigarettes per day?** _____

How long (have) did you smoke (d)? _____

If you quit, when did you quit? _____

How many glasses per week do you consume of? WINE _____**BEER** _____**COCKTAILS**_____

Has anyone in your family had any of the following illnesses?

WHICH FAMILY MEMBER **HOW OLD WERE THEY**

Cancer _____

Heart Attack _____

Angina or clogged arteries_____

Sudden death _____

Hypertension _____

Other heart disease _____

High cholesterol _____

Stroke _____

Diabetes _____

Are you having or have you ever had? (check all for which the answer is "yes").

☐ **Increasing Breathlessness With Your Usual Activities**
☐ **Unexpected weight gain of more than 5 lbs in the last weeks or months**
☐ **Pain, pressure/discomfort in the chest**
☐ **Shortness of breath at rest, laying down**
☐ **Any neck, jaw, left arm discomfort**
☐ **Pain or cramps in leg(s) with walking**
☐ **A stroke or temporary stroke**
☐ **Spells of rapid irregular heartbeat**
☐ **Urination at night**
☐ **Abnormal EKG**
☐ **Recent Cough**
☐ **Passed (ing) out-fainting**
☐ **worsening fatigue**
☐ **Swelling of the ankles**
☐ **Dizzy spells**
☐ **Heart murmur**
☐ **Heart attack**
☐ **Rheumatic fever**
☐ **Varicose veins**
☐ **Have you ever been hospitalized for your heart, or what they thought was your heart?**
☐ **Any other cardiac diagnosis?** _____

☐ **Any tests done for your heart? What tests?** _____

When where they done? _____

Are there any problems you wish to address at this visit?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient name (sign) **Date**

_____

Witness **Date**

INSURANCE INFORMATION

Please provide us with your medical insurance information:

PRIMARY INSURANCE POLICY:

Company: _____Phone:_____

Policy #: _____Group:_____

Name and SS# of Insured: _____

SECONDARY INSURANCE POLICY:

Company: _____Phone:_____

Policy #:_____Group:_____

Name and SS# of Insured: _____

OTHER INSURANCE:

Company:_____Phone:_____

Policy #: _____Group:_____

Name and SS# of Insured: _____

ASSIGNMENT BENEFITS

I HEREBY ASSIGN TO MICHAEL RICHMAN M.D., MY RIGHT TO AND INTEREST IN ANY AND ALL HEALTH CARE AND /OR SURGICAL BENEFITS, OTHERWISE PAYABLE TO ME, FOR MEDICAL AND/OR SURGICAL TREATMENT RENDERED BY ANY OF THE ASSIGNEES. I HEREBY DIRECT MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO THE ASSIGNEE AT 1950 SAWTELLE BLVD # 150 LOS ANGELES, CA 90025.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY(DZS), UNLESS SUCH CHARGES ARE LIMITED BY EXISTING CONTRACT AGREEMENTS BETWEEN THE ASSIGNEE AND MY MEDICAL CARRIER, AND THAT FINANCE CHARGES WILL BE ADDED TO ANY OUTSTANDING BALANCE, STARTING THIRTY DAYS FROM THE DATE A BILL IS SUBMITTED TO MY INSURANCE COMPANY, OR FROM THE DATE OF MY FIRST STATEMENT, IF CHARGES ARE NOT COVERED BY MY INSURANCE COMPANY, I AUTHORIZE THE PHYSICIAN LISTED ABOVE TO RELEASE TO MY INSURANCE COMPANY/OR ITS REPRESENTATIVES OR AGENTS, ANY MEDICAL INFORMATION RELATIVE TO THE SERVICES RENDERED TO ME. I ACKNOWLEDGE THAT A PHOTOCOPY OR FAX OF THIS ORIGINAL IS AS VALID AS THE ORIGINAL.

Your signature (required):_____Date:_____

PRIVACY OF MEDICAL RECORDS

Our physicians and staff are fully and acutely aware of the potentially sensitive nature of the information contained in your medical record. Therefore, we ask that you provide us below with a list of those individuals or parties whom you intend to have access to such information in your medical records, and those whom you do not. Unless you request otherwise, it is our policy to share such information with the following individuals or parties:

1. Your next of kin, usually identified as the emergency contact and/or the person(s) who accompanies you during your office visit(s), spouse, child (ren), and/or parent(s);
2. Your medical insurance carrier and its agents;
3. Your referring physician and his/her staff;
4. The physicians and professionals to whom we make referrals, including the pathologist, radiologist, and anesthesiologist, and their staff.

We CANNOT bill your insurance company and/or collect any money from them on your behalf unless we have your permission to disclose such information to them. Also, the quality of your medical care might be compromised if our physicians do not have your permission to consider your case fully and frankly with other physicians and professionals who are involved in your medical care.
Please acknowledge below that you permit the foregoing individuals or parties to have access to the information contained in your medical records by signing below, and list additional individuals or parties that you permit access to such information.

THE FOLLOWING IS A LIST OF ADDITIONAL INDIVIDUALS OR PARTIES WHO HAVE MY PERMISSION TO ACCESS THE INFORMATION CONTAINED IN MY MEDICAL RECORD (IF THERE ARE NONE, WRITE IN "NONE"):

Your signature (required): _____Date:_____

Please acknowledge below any individuals or parties that you DO NOT authorize access to the information contained in your medical record by signing below.

THE FOLLOWING IS A LIST OF INDIVIDUALS OR PARTIES WHO DO NOT HAVE MY PERMISSION TO ACCESS THE INFORMATION CONTAINED IN MY MEDICAL RECORD (IF THERE ARE NONE, WRITE IN "NONE"):

Your signature (required): _____Date:_____

THE CENTER FOR CHOLESTEROL MANAGEMENT
A Medical Corporation

BILLING POLICY

We would like to prevent any misunderstanding about our billing financial policies. Please let the office administration know of you would like to discuss any of the following policies in more detail.

If you belong to an HMO, or any other restricted insurance plan, you MUST let us know before you are treated. Some of these plans limit your choice of doctor or hospital, and some exclude particular medical conditions. If you need surgery, we will try to select the hospital and doctors from your plan, although this might not always be possible or practical, particularly with the pathologist and the radiologist. Please provide our business office with all of your insurance information before you are treated, and we will help you fulfill the terms of your policy so that you can obtain maximum and timely reimbursement.

We will send you monthly statements until your insurance company has paid, regardless of our provider status. This allows you to verify that your insurance company was billed correctly, and to see how long they take to pay. If you have more than one insurance policy and the benefits are not coordinated, each company will determine benefits separately. In this situation, it might happen that we have different agreements with different companies. We will then collect benefits from each company and reimburse you any amount above billed charges.

We accept Visa, MasterCard, and Diner's. There is a $25 charge for all checks returned by the bank. If you would like us to bill your insurance company on your behalf, please complete the Assignment of Benefits sections below. Please sign below once you have had a chance to review our billing policies.

I AUTHORIZE MICHAEL RICHMAN M.D. AND STAFF TO PROVIDE ME WITH REASONABLE AND PROPER MEDICAL CARE.
I UNDERSTAND THAT I WILL HAVE AN OPPORTUNITY TO ASK QUESTIONS AND TO HAVE MY QUESTIONS ANSWERED, BEFORE I DECIDE TO PROCEED.

Your signature (required): _____Date:_____

The Center for Cholesterol Management

Cancellation policy

The Center for Cholesterol Management requires that a **24 hours**' notice be given for cancellation or rescheduling of appointments. Failure to properly notify this office of any changes may result in a **$25 dollar charge**.

Thank you for your cooperation!

Your signature (required): _____Date:_____