

Dr. Babak Eghbalieh (SoCal Hepatobiliary)
Dr. Sammy Eghbalieh (SoCal Vein & Artery)

Date: _____

Central Office: 5805 Sepulveda Blvd # 690, Sherman Oaks CA 91411-2522

PLEASE PRINT VERY CLEARLY

Line items printed in **bold** on this page are <u>required fields</u>, if they apply. Thank you for your assistance.

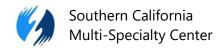
Name (Last, First, Middle)	= = = = = = = = = = = = = = = = = = =					
Birthdate Soc. Sec. #		Home Phone	Home Phone			
Email address		Cell Phone				
Address	Apt #	Work Phone				
City	State	Zip				
Marital Status: ☐ Single ☐ Marri	ed □ Divorced □ Wido	wed ☐ Separated	Sex:	\square M	□F	
Race: ☐ Black / African American ☐ White		Islander □ American Indian □	Asian 🗆 U	nknown [☐ Other	
Ethnicity: □ Hispanic □ Non-Hispanio						
Preferred Language: ☐ English ☐ S	Spanish □ Hmong □ Lao □ P	unjabi □ Sign Language □ V	ietnamese 🛘	Other:		
How did you find us? ☐ self ☐ frien	d □ social media □ referral □	web search □ other:				
■ Person Financially Resp	onsible for Account (#	same as patient write "same" (on Name line)	ı		
Name (Last, First, Middle)						
Birthdate		•				
Difficultie						
■ Primary Insurance						
Policyholder's Name (Last, First, Middle	.	Relationship				
Policyholder's Date of Birth						
Address						
City						
Employer's Name (if insurance is through w						
■ Secondary Insurance						
Name (Last, First, Middle)		Home Phone				
Date of Birth	Soc. Sec. #	Work Phone				
Address	Apt #	Cell Phone				
City	State	Zip	Sex:	\square M	□F	

of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to

be used in place of the original. I have read and agree to the above.

Signature:

Date: _____



Contact #1:

PLEASE PRINT VERY CLEARLY

Line items printed in **bold** on this page are <u>required fields</u>, if they apply. Thank you for your assistance.

■ Emergency Contact Information (please provide two emergency contacts)

Name (Last, First, Middle)

Signature: _____

The information is confidential and is covered by the provisions of the *Freedom of Information and Protection of Privacy Act*.

Relationship:		Home Phone	
Email address		Cell Phone	
Address	Apt #	Work Phone	
City	State	Zip	
Contact #2:			
Name (Last, First, Middle)			
Relationship:		Home Phone	
Email address		Cell Phone	
Address	Apt #	Work Phone	
City	State	Zip	
■ Assignment and Re	lease		
In the event of an emergency, California Multi-Specialty Cent Hepatobiliary Pancreatic and Ro Specialists, Inc) to contact and information in regards to treat interventions pertaining to my ca	ter (and/or its subsobotic Surgery Institu I inform the above li Itments, procedures(s	sidiaries, including Southe te, and Southern California sted individuals and reveal), surgery and other relev	ern California Vein & Artery my personal

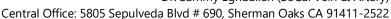
Patient Name:			Date of Birth:		
■ Other Medical Providers					
Referring Physician			Phone		
Primary Care Physician			Phone		
Pharmacy Name			Phone		
Pharmacy Address					
Dialysis Center:					
■ Health Problems					
	<u>Yes</u>	No		Yes	No
Stroke			Allergies		
Heart Disease			Kidney Disease		
Heart Attack			Jaundice / Hepatitis		
Rheumatic Fever			High Blood Pressure		
Emphysema			Cancer		
Tuberculosis			Back Problems		
Pneumonia			Arthritis		
Bleeding / Clotting Problems			Stomach / Ulcer Problem		
Speech / Hearing Problems			Diabetes		
Other			Blood Transfusion (Dates:)□	
Brovious Surgorios Cirolo de la companya del companya de la companya de la companya del companya de la com	all that apply as	ad liet de	hto(a)		
■ Previous Surgeries Circle a Ear / Nose / Throat			Hysterectomy		
Appendectomy			Hernia		
Eye			Hemorrhoid		
Breast			Back / Neck		
Gallbladder			Joints (Hip / Knee)		
Heart / Bypass			Carotid Surgery		
Balloons or stents in blood vessels: If ye	es, which locations	and dates	?		
Aneurism surgery: If yes, open or closed, an	d which locations a	and dates?			
Other hospitalizations: List reasons and dat	tes				
■ Family History					
	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Heart Disease			Cancer		
Diabetes			Stroke		
High Blood Pressure			Other:		

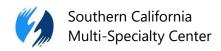
Patient Name:	Date of Birth:	

■ Current Condition Please answer these items as of today.

Constitutional Symptoms			Gastrointestinal	
Good general health lately	Yes	□ No	Loss of appetite Ye	s 🗆 No
Recent weight gain	Yes	□ No	Change in bowel movements ☐ Ye	s 🗆 No
Recent weight loss	Yes	□ No	Nausea or vomiting ☐ Ye	s 🗆 No
Fever	Yes	□ No	Frequent diarrhea 🗆 Ye	s 🗆 No
Fatigue	Yes	□ No	Painful bowel movements 🗆 Ye	s 🗆 No
			Constipation Ye	s 🗆 No
Eyes			Rectal bleeding or blood in stool ☐ Ye	s 🗆 No
Eye disease or injury	Yes	□ No	Abdominal pain or heartburn ☐ Ye	s 🗆 No
Wears glasses or contact lenses □	Yes	□ No	Peptic ulcer (stomach or duodenal) ☐ Ye	s 🗆 No
Blurred or double vision	Yes	□ No		
Glaucoma	Yes	□ No	Genitourinary	
			Frequent urination	s 🗆 No
Ears / Nose / Throat / Mouth			Burning or painful urination 🗆 Ye	s 🗆 No
Hearing loss or ringing	Yes	□ No	Blood in urine 🗆 Ye	s 🗆 No
Earache or drainage	Yes	□ No	Change in force or strain when urinating ☐ Ye	s 🗆 No
Chronic sinus problem / rhinitis	Yes	□ No	Incontinence or dribbling ☐ Ye	s 🗆 No
Nose bleeds	Yes	□ No	Kidney stones □ Ye	s 🗆 No
Mouth sores	Yes	□ No	Sexual difficulty □ Ye	s 🗆 No
Bleeding gums	Yes	□ No	Men: testicle pain ☐ Ye	s 🗆 No
Bad breath or taste in mouth	Yes	□ No	Women: painful periods ☐ Ye	s 🗆 No
Sore throat	Yes	□ No	Women: irregular periods ☐ Ye	s 🗆 No
Voice change	Yes	□ No	Women: vaginal discharge ☐ Ye	s 🗆 No
Swollen glands in neck	Yes	□ No		
			Musculoskeletal	
Cardiovascular			Joint pain□ Ye	s 🗆 No
Heart trouble	Yes	□ No	Joint stiffness or swelling ☐ Ye	s 🗆 No
Chest pain or angina pectoris □	Yes	□ No	Weakness of muscles / joints ☐ Ye	s 🗆 No
Palpitations	Yes	□ No	Back pain □ Ye	s 🗆 No
Short of breath when walking	Yes	□ No	Cold extremities Ye	s 🗆 No
Short of breath when lying down	Yes	□ No	Difficulty in walking ☐ Ye	s 🗆 No
Swelling of feet, ankles or hands	Yes	□ No		
			Integumentary (skin, breast)	
Respiratory			Rash or itching Ye	s 🗆 No
Chronic or frequent cough	Yes	□ No	Change in skin color ☐ Ye	s 🗆 No
Spitting up blood	Yes	□ No	Change in hair or nails ☐ Ye	s 🗆 No
Shortness of breath	Yes	□ No	Varicose veins ☐ Ye	s 🗆 No
Difficulty breathing	Yes	□ No	Breast pain □ Ye	s 🗆 No
Sneezing	Yes	□ No	Breast lump □ Ye	s 🗆 No
			Breast discharge □ Ye	s 🗆 No
Psychiatric				
Memory loss or confusion	Yes	□ No		
Nervousness	Yes	□ No		

Patient Name:	Date of Birth:			
■ Current Condition conti	nued			
Neurological		Hematologic / Lymphatic		
Frequent or recurring headaches	□ Yes □ No	Slow to heal after cuts	□ Yes	□ No
Light headed or dizzy	□ Yes □ No	Bleeding or bruising tendency	□ Yes	□ No
Convulsions or seizures	□ Yes □ No	Anemia	□ Yes	□ No
Numbness or tingling sensation	□ Yes □ No	Phlebitis	□ Yes	□ No
Tremors	□ Yes □ No	Enlarged glands	□ Yes	□ No
Paralysis	□ Yes □ No	History of DVT	□ Yes	□ No
Stroke	□ Yes □ No	History of pulmonary embolism	□ Yes	□ No
Head injury	🗆 Yes 🗆 No	Family history of clotting or bleeding disor	der□ Yes	□ No
Endocrine		Allergic / Immunologic		
Glandular or hormone problem	□ Yes □ No	Skin reaction or other adverse reaction to:		
Thyroid disease	□ Yes □ No	Penicillin or other antibiotic	□ Yes	□ No
Diabetes	□ Yes □ No	Morphine, Demerol or other narcotics	□ Yes	□ No
Excessive thirst or urination	□ Yes □ No	Novocaine or other anesthetics	□ Yes	□ No
Heat or cold intolerance	□ Yes □ No	Aspirin or other pain remedies	□ Yes	□ No
Skin becoming drier	□ Yes □ No	Tetanus antitoxin or other serum	□ Yes	□ No
Change in hat or glove size	□ Yes □ No	lodine, Merthiolate or other antiseptic	□ Yes	□ No
History of dialysis	□ Yes □ No	CT or MRI contrast injection	□ Yes	□ No
■ Are you on any of these Please answer these items as of too Aspirin Warfarin / Coumadin Plavix Elequis Xarelto		Brilinta	Yes Yes Yes	□ No □ No □ No
Nonsteroirdal Anti-inflammatory (NSA	AIDs)			
Advil	□ Yes □ No	Mediprin		□ No
Alleve	🗆 Yes 🗆 No	Motrin	🗆 Yes	□ No
Bextra	□ Yes □ No	Naproxin	🗆 Yes	□ No
Celebrex	□ Yes □ No	Nuprin	□ Yes	□ No
lbuprofen	🗆 Yes 🗆 No	Vioxx		□ No
Herbal Supplements and vitamins that	at thin the blood:			
Fish oil		Flax Seed		
Vitamin E	☐ Yes ☐ No	Omega 3 supplements	🗆 Yes	□ No
Gingko Biloba	🗆 Yes 🗆 No	Ginseng	🗆 Yes	□ No





POLICIES AND PROCEDURES

Health Insurance Cards: Please bring your most current health insurance membership card to each and every appointment. Intentionally failing to notify us of changes to your insurance coverage may constitute insurance fraud, and we may be obliged to report it to the authorities.

Keeping Appointments: Appointments must be cancelled with at least 1 full business day's notice for office appointments, and 3 full business days' notice for surgical procedures. Failure to show for an office visit, or cancellation on less than 24 hours' notice, constitutes a no-show and is subject to a \$50 fee. Failure to show for a surgical procedure, or cancellation on less than 3 days' notice, constitutes a no-show and is subject to a \$250 fee. Cancellation due to lack of referral (see below) is considered a no-show. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

Health Insurance Plans: Although we may advise you whether we believe we participate with your insurance carrier, we are not responsible for any assurances made to you regarding whether particular services rendered in this practice are covered by your plan. You and you alone are responsible to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your financial responsibilities and our participation status in your specific network.

Referrals and Prior Authorizations: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). If you come to an appointment without a required referral, and you must reschedule, the canceled visit may be considered a no-show, as above.

Medicare: If you have coverage with original Medicare (this means Medicare directly from the government) or Medicare Advantage (this means Medicare provided through a commercial carrier) it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and a 20% coinsurance. Any portion of this deductible and coinsurance that is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitations, regardless of whether you are aware of the details. If you have both Medicare and another insurance, <u>you</u> are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, and/or is not paid within 60 days from the date of service, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding this provision.

In-Network Commercial Insurance: If you have an insurance plan with which the provider does participate, and under which you have in-network benefits, we shall file claims with the insurance carrier and, upon receipt of carrier adjudication, will invoice you for any balance which may be applied to your financial responsibility. If your plan has a copayment, it is your responsibility to pay it in full at the time of service, even if the amount it not printed on your insurance card. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, you will be responsible to pay an invoice fee of \$15. If your insurance carrier advises us that the amount of your copayment is higher than what is printed on the card you provide, you are responsible for payment of the difference. If your plan advises us at any time that you do not have coverage for the services rendered, or your policy is exhausted, or you are not covered for services rendered for any reason, even retroactively, you will be responsible for the entire balance.

Out-of-Network Commercial Insurance: If you have an insurance plan with which we do <u>not</u> participate, but under which you have out-of-network benefits, we may agree to file claims for services rendered. You may be required to pay for some or all of the charges upfront toward your obligation for services rendered, and after receiving the insurance carrier adjudication we may bill you for the balance.

If your plan advises us at any time that you do not have coverage for the services rendered out-of-network, or your policy is exhausted, or you are not covered for services rendered for any reason, you will be responsible for the entire balance. If your plan issues payment to us for services rendered out-of-network, you may be responsible for some or all of the balance, which we will invoice you for. If your plan makes payment directly to the patient or policy holder for services rendered, you are responsible to turn the entire payment over to us immediately upon receipt, by endorsing the check over to Southern California Multi-Specialty Center, along with a complete copy of the Explanation of Benefits. Should you be issued payment by the insurance carrier and not promptly turn it over to us in whole,

POLICIES and PROCEDURES Page 1 of 2

legal action will be pursued and you may be discharged as a patient from this practice. After turning over the insurance carrier's payment, you may remain responsible for some or all of the balance, which we will invoice you for. We may only submit claims to your primary insurance – you may be given a receipt which you can submit to secondary insurance. Balance bills are due immediately upon receipt.

Health Insurance Non-Payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. In cases of retroactive disenrollment, you are responsible immediately upon notification to us by the carrier. This policy applies equally to in-network and out-of-network plans. If your insurance carrier later makes payment on such a claim, you will be reimbursed for your payment, minus any amount which has been applied to your financial responsibility by your in-network insurance carrier.

Balances and Collections: It is our right and responsibility to bill you for any portion of your treatment your medical insurance assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance policy, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections. If that happens, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. If you bounce a check, you will be responsible for a \$35 fee, and will not be able to pay by personal check again. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

Self-pay patients: If you do not have health insurance, or are receiving services known to not usually be covered, it is our policy that you must pay for those services before leaving the office. If you have insurance through an out-of-network insurance to which we do not agree to submit claims on your behalf, you may ask for a receipt at the time of service.

Smoke Free Environment: Southern California Multi-Specialty Center is a smoke free environment. Smoking (including smokeless tobacco, electronic cigarettes and vaping, regardless of tobacco content) is prohibited at any of our locations.

Weapon Free Environment: Southern California Multi-Specialty Center strives to maintain an environment free from violence and intimidation. Weapons of any kind are prohibited on all our properties, with the exception of authorized law enforcement officers. For the purposes of this policy, weapons are defined as any implement or tool whose primary function is to cause bodily harm to the person against whom it is used.

Energy Fields: Southern California Multi-Specialty Center and its subsidiaries render services at locations (including but not limited to those owned and rented by it/them) which contain hazardous energy fields or radiation, such as x-rays. Patients who are pregnant (including those who think they may be pregnant) and/or susceptible to radiation should notify the medical staff. By signing below you hereby release the owners, physicians and staff of Southern California Multi-Specialty Center and its subsidiaries from all suits, claims, liability, or demands of every kind and character which you or your heirs, executors, administrators or assigns hereafter can, shall, or may have arising out of your presence at any of these locations.

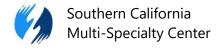
Laboratory Testing: If you are a member of an insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office is so informed by you, we will happily send your specimens to that laboratory, unless the provider determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory, and shall handle financial matters directly with the laboratory.

Privacy: A person is liable for constructive invasion of privacy when they attempt to capture any type of visual image, sound recording or other physical impression of another individual engaging in a personal or familial activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than \$5,000 and not more than \$50,000 [California Civil Code, Section 1708.8]. Southern California Multi-Specialty Center complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

I have read, fully understand, accept and agree to comply with all the above provisions, policies and conditions. I consent to the assignment of authorized health insurance benefits by my health insurer to Southern California Multi-Specialty Center (and its subsidiaries) for any services furnished to me or my dependents. I authorize any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original.

Patient Name (Please print clearly):	_	
Signature of Patient:	Date:	

POLICIES and PROCEDURES Page 2 of 2



Central Office: 5805 Sepulveda Blvd # 690, Sherman Oaks CA 91411-2522

PATIENT CONSENT TO PHOTOGRAPHY

The Department of Health and Human Services has established a provision known as the Privacy Rule, as a result of passage of the HIPAA law and its omnibus. It was created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of protected health information.

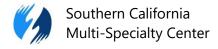
As our patient, we want you to know that we respect the privacy of your personal medical records, and will take all reasonable efforts to secure and protect that privacy in compliance with the law. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your healthcare information and information about treatment, payment, or healthcare operations, to provide healthcare that is in your best interest. Part of your treatment may include photographs and/or video of your face and other body parts. We may also desire to use the photographs and/or video taken of you by our office for treatment, educational, and/or advertising purposes. However, prior to using any photographs and/or video for advertising purposes we will obtain consent from the patient, parent, or legal guardian.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any concerns about this policy or form, please ask to speak with our HIPAA Compliance Officer.

INFORMED CONSENT TO PHOTOGRAPH

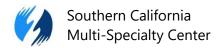
I, (print name of patient or legal guardian)	, do hereby give consent to Southern California						
Multi-Specialty Center, and its subsidiaries, to take and	l/or display photographs and/or video of the patient's face						
and other body parts. The photographs or video will be	e used as part of medical information, educational and/or						
advertising purposes by Southern California Multi-Specialty Center and/or its subsidiaries, and may also I							
displayed within the office and/or the office's webpage.	The doctors and office staff will protect my personal data,						
such as name, age and date of birth, from being display	ed.						
I further understand that if the photograph(s) and/or vi	deo are used, I do not expect compensation, financial or						
otherwise, of the use of these photographs and/or video	• • • • • • • • • • • • • • • • • • • •						
	, and hand an each righter						
D.C. (N							
Patient Name (please print clearly):							
O							
Signature of Patient:	Date:						
Signature of Witness:	Relationship:						



Central Office: 5805 Sepulveda Blvd # 690, Sherman Oaks CA 91411-2522

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

 I have received your Notice of Privacy Practi review it. 	ces and/or I have been provided an opportunity to
and all other Protected Health Information* ("Pl	ly appointments, prescription renewals, test results, HI"), may be left for me on voicemail systems and numbers, in addition to any other numbers provided
()	Home / Office / Cell / Other:
()	Home / Office / Cell / Other:
()	Home / Office / Cell / Other:
♦ I agree that my PHI may be shared with my sp	pouse (if applicable).
◆ I agree that my PHI may be shared with my ot	ther medical providers.
◆ I agree that my PHI may be shared with the fo	ollowing other people:
	regoing agreements, at any time, by giving written ter to the attention of the HIPAA Compliance Officer.
 I agree that Southern California Multi-Specialty email addresses provided to you by me regarding 	y Center and its subsidiaries may contact me at any ng both PHI and non-PHI.
*as defined in the Health Insurance Portability and Accou from time-to-time ("HIPAA")	ıntability Act of 1996 and its regulations, as may be amended
Patient Name (Please print clearly):	
Signature of Patient:	Date:



MEDICAL RECORDS RELEASE

I hereby request pr	otected health information to	be released from the medica	al record of:
	Patient Name:		
	Patient's Date of Birth:		
	Release Records From:		
	Send Records To: Southern California Multi-Sp 5805 Sepulveda Boulevard Suite 690 Sherman Oaks CA 91411-2 Fax: (818) 900-6488	,	
This request and	authorization applies to: (ch	eck appropriate selection)	
☐ All healthcare in	formation.		
☐ Only healthcare	information relating to the foll	owing treatment, condition o	or date(s):
but not limited t	and request the prompt rele o clinical notes, lab tests nsultations and secondary r	, pathology reports, radio	
Patient Name (Plea	ase print clearly):		
Signature of Patier	t:	Date:	