NYC PAIN SPECIALISTS

a Trusted Pain Physician Company

P: 212.371.8460
F: 212.537.7303

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Rene Hilderbrand, MSPAS, D.O.
Shamas Chungez-Kiani, D.O.
Roy Berenholtz, M.D.
Julissa Cruz, M.D.
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New York, New York, 10019

Greenwich Village Pain Institute & Surgery Pavilion
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RESTORE THE HEALTH AND BEAUTY OF YOUR LEGS

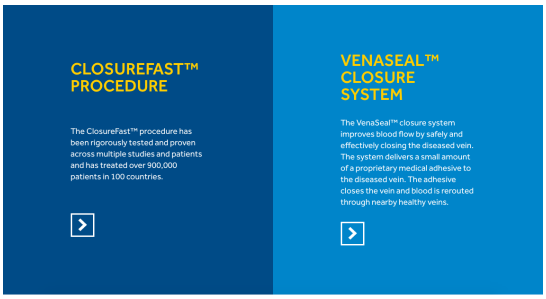
The Vein Center at Greenwich Village Pain Institute & Surgical Pavilion

Venous reflux disease is chronic and progressive.

Do you suffer from these symptoms: Itching? Ulcers or Sores? Spider Veins? Burning? Cramping? Tired Legs? Skin Changes? Restless Legs? Unsightly Varicose Veins? Heaviness? Aching? Swelling?

The only regional clinic offering both thermal and nonthermal treatments of spider and varicose vein disorders.

*** * * MOST TREATMENTS ARE COVERED BY INSURANCE * * ***



<u>Our Board Certified Doctors can help assess if this treatment is an option for you.</u>

Welcome to NYC Pain Specialists at Greenwich Village Pain Pavilion & Surgery Center. We are proud to be one of New York's only practices dedicated exclusively to the diagnosis and treatment of vein disorders. Our goal is to help you overcome the embarrassment and discomfort of varicose veins so that your legs look and feel their best. We look forward to meeting you and are committed to providing the most comprehensive office-based vein care treatments available.

Our team of Board Certified Physicians offers expertise in vein care with many treatment options. Our combination of treatments includes a variety of minimally invasive procedures that provide beneficial medical and cosmetic results.

Your consultation is comprised of a thorough evaluation including complete medical history, physical exam, and when indicated, duplex ultrasound of your legs to evaluate the size and function of your veins. Finally, we will discuss any treatment options that may be indicated.

Enclosed are several items that will acquaint you with our practice and provide information about your upcoming appointment. We encourage you to take a few moments to look through this packet. If you have any questions or concerns, please feel free to call a member of our staff.
At NYC Pain Specialists, we understand your time is valuable. Our goal is to provide quality healthcare in a timely manner. ***<u>Please complete the enclosed forms, and bring them with you to your appointment</u>***. ***<u>Please arrive 30 minutes before your scheduled appointment to allow time for the check-in process.</u>***

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Media Consent

I irrevocably grant Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries the perpetual, unrestricted, royalty-free right and permission, throughout the world in any existing or subsequently invented media, to use, reproduce, display, sell, publish, and reuse and republish my treatment, including my first name, last name and city of New York, and any and all **images or video** of me taken on the date and at the location listed below. "Images" include, but are not limited to, videos, photographs, negatives, video and digital images of me provided to Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries and any derivative works created there from. I consent to all uses of the treatment story, my first and last name, city of Hartsdale and Images.

I waive any right to view, inspect or approve any use of any Image and materials incorporating any Image now in the future, whether that use is known to me or unknown. I consent to the use of any printed matter or text or otherwise, in conjunction with a ny and all uses of my Images. All Images are the copyrighted property of Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries. Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries may also choose not to use the Images.

My treatment story as shared with Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries in the form of my written testimony attached hereto, or other information shared verbally with Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries representatives, may be reproduced and published in whole or in part and may be adapted in any manner to facilitate its use in connection with Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries aesthetics program as the general sense of the story is not changed.
I have received no monetary compensation for the use of my story and/or Images.

I agree that I will not hold Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries or any of its affiliates or agents responsible for any liability resulting from the use of treatment story and/or my Images in the manner described above, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper or via electronic media, from and against all claims, damages or liability arising from or related to the use of the Images, including by not limited to any misuse, distortion, blurring, alteration, optical illusion or use in composite form, whether intentionally or otherwise, that may

occur or be produced in taking, processing, reduction or production of the finished product, its publication or distribution. I understand that Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries cannot prevent unauthorized third parties from downloading, copying, and/or distributing my treatment story or Images from the Internet.

I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific question regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release. This release constitutes the entire agreement between me and Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries and cannot be changed unless amended in a writing signed by Dr. Karan Johar, KARAN JOHAR MD PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE PLLC, NYC PAIN SPECIALISTS and all subsidiaries and me. All prior agreements on this subject have been incorporated into this release. If any provision of this release is invalid, the remaining provisions continue in full force and effect. The laws of the state of New York govern this release. This release shall be binding upon me and my heirs, legal representatives, and assigns. I am over 21 years of age, am competent to contract in my own name and have the right to make this agreement.

Print Name: _____ **Date:** _____

Signature: _____

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NAME: _____ **DOB:** _____ **DATE:** _____

Vein History

Please circle any of the symptoms that apply to you:

Aching leg Burning Tiredness Dull Pain Heaviness Itching Leg Ulcers
Restless Legs Sharp Pain Swelling Throbbing Numbness Tingling Other: _____

Do you have (now or in the past): Varicose Veins Spider Veins Skin Ulcers

When did you first notice enlarged or discolored veins, or begin experiencing leg discomfort? _____

Is the problem getting worse? Yes No

Where are the veins you are seeking a medical opinion for located? Face Leg(s) – Right / Left

Is the leg discomfort aggravated by: Standing Walking Exercise Other: _____

Is the leg discomfort relieved by: Walking Leg Elevation Medication Other: _____

Have you ever worn prescription grade compression stockings? No Yes, if so for when and for how long? _____

Do you have a family history of vein problems? No Yes, if so what family member? _____

Is there a family history of blood clots in the legs or lungs? No Yes, if so what family member? _____

Do you take any medications for pain in your legs? No Yes, if so which? _____

Have you ever had any of the following? If yes, when? : Date(s) _____

Skin ulcer on your leg Previous Vein surgery Bleeding from varicose veins? Clotting disorder?

Deep vein blood clot (DVT) Pulmonary embolus (blood clot to lungs) Phlebitis (clot in surface vein of leg)

Sclerotherapy Trauma/injury to your legs HIV/Hepatitis IV Drug Use

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Habits

Do you drink alcoholic beverages? No Yes (#/week _____)

Do you now or have you ever used tobacco? No Yes (Packs/week _____) Quit Date, if applicable _____

Medications (please list all prescriptions, over-the-counter medications, and herbs/supplements

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies (please list any allergies to medications, latex, etc.)

_____ _____ _____ _____
_____ _____ _____ _____

Past Medical History (please circle)

Thyroid abnormalities Asthma COPD Atrial fibrillation Murmur

Diabetes Cancer High cholesterol Glaucoma Migraine headaches Depression

Anemia Angina (chest pain) Arthritis Heart attack High blood pressure Acid reflux (GERD)

Spinal stenosis Stroke/seizures/TIA Osteoporosis/Osteopenia Other: _____ _____

Past Surgical History (Please list surgeries and dates):

_____ _____ _____ _____ _____

Females Only:
Are you pregnant? No Yes Number of Pregnancies _____ Number of Deliveries _____ Miscarriages _____

Height: _____ ft _____ inches Weight: _____ lbs

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Review of Systems: Have you recently had any of the following symptoms?

Trouble sleeping Lungs/Breathing Neurological Chest Pain Headaches

Thyroid Fatigue Nausea Vomiting Bleeding Vision Memory Dizziness

Psychiatric Skin Ringing in Ears Joints/Bones Muscles Reproductive Urinary

CEAP Clinical Classifications:

(C) Class – 0 asymptomatic with no visible or palpable signs of venous disease, 1 spider veins, reticular veins, telangiectasias, 2 varicose veins, 3 edema, 4 skin changes, 5 healed ulcer, 6 active ulcer
(E) Etiology - congenital, primary disease, secondary disease
(A) Anatomic Findings – alone / in combination - superficial, deep, perforator
(P) Pathophysiology Dysfunction – Reflux, Obstruction, Both Reflux and Obstruction

Venous Clinical Severity Score				
Attribute	**Absent = 0**	**Mild = 1**	**Moderate = 2**	**Severe =3**
Pain	None	Occasional, Not restricting activity or requiring pain medication	Daily Moderate Activity Limitation; Occasional Pain Medication	Daily, Severe Limiting activities or requiring
Varicose Veins	None	Few Scattered	Multiple; great saphenous veins, confined to calf and thigh	Extensive; thigh and calf or great and small saphenous distribution
Venous edema	None	Evening ankle swelling only	Afternoons swelling, left ankle	Morning swelling above ankle and requiring activity change, elevation
Skin pigmentation	None	Diffuse, but limited an area and old (brown)	Diffuse over most of gaiter distribution (lower third) or recent pigmentation (purple)	Wider distribution (above lower third) plus recently mentation
Inflammation	None	Mild cellulitis, limited to marginal area around ulcer	Moderate cellulitis, involves most of (lower third)	Severe cellulitis (lower third and above) or significant
Induration	None	Focal, ciccummalleolar	Medial or lateral, less than lower third of leg	Entire lower third of leg or more
Number of active ulcers	0	1	2	>2
Active ulcer duration	None	<3 months	> 3 months, <1 year	Not healed> 1 year
Active ulcer diameter	None	<2	2-6	>6
Compression therapy	Not used for patient not compliant	Intermittent use of stockings	Wears elastic stocking most days	Full compliance, stockings + elevation

_____ _____

Patient Signature **Date**

_____ _____

Physician's Signature **Date**

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Endovenous Radiofrequency Ablation Patient Consent Form

RIGHT _____ LEFT _____

I hereby authorize Dr. Johar and/or _____ (Provider(s)) to close my saphenous vein(s) using an endovenous radiofrequency obliteration technique. He has explained that the devices perform this procedure isn't commercially available product is specifically for this purpose. I understand that alternative treatments for obliteration of function for the saphenous vein include ligation (cutting or tying the vein in the groin or behind the knee), stripping the vein (pulling along segment out), or compression sclerotherapy (injecting mechanical to occlude the vein).

The Provider(s) has explained that, in symptoms of varicose veins, such as heaviness in pain after standing for a long time, arise from malfunctioning valves in the saphenous vein (the main external vein in the thigh and calf). The resulting increased pressure in the saphenous vein is transmitted to my varicose veins. Satisfactory treatment of varicose veins symptoms is usually achieved by obliterating the saphenous vein. Although closure of the saphenous vein should reduce the pressure in my varicose veins and thus relieve many of my symptoms, I understand this consent for this endovenous radiofrequency ablation procedure for treatment of my saphenous vein does not include actual removal of the varicose veins, which may still be visible. I also understand that my insurance company has not approved reimbursement for the saphenous pain and will not reimburse Provider(s) for the procedure of actually removing the cosmetically objectionable varicose veins.

The general nature of the endovenous radiofrequency ablation procedure for treatment of the saphenous vein has been explained to me. I understand that amongst the known risks of this procedure are failure to close the saphenous vein, leg swelling, bruising, mild phlebitis (pain, tenderness, redness) over the treated vein, numbness and tingling in the treated area, and skin burns that and may need to be treated with additional surgery. I'm aware that in addition to the risk specifically described above, there are other risks that may accompany any surgical procedure, such as intra- and postoperative blood loss, infection, and clot formation in the venous system.

The Provider(s) have not guaranteed either the results of the surgery or freedom from potential complications. I've had sufficient opportunity to discuss my condition and proposed treatments with the Provider(s) and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base and informed consent for treatment.

_____ _____
Patient Signature **Date**

_____ _____
Witness Name + Signature **Date**

I have informed the patient of the available alternatives to the endovenous radiofrequency ablation procedure for treatment of the saphenous vein, and of the potential surgical risks, complications and results that may occur as resulted.

_____ _____
Physician's Signature **Date**

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Preoperative Instructions

1. Compression Stockings: Properly fitted stockings are required for all procedures. Please obtain them as soon as possible. Rubber gloves must be worn when putting on stockings to prevent damaging stockings. Some insurance providers may require patients to wear stockings for a time before approving surgery. **Please be fitted 3 weeks prior to your procedure as your size may not be in stock.** To help make these veins more obvious, patients should not wear compression stockings for at least 5 days prior to surgery. Do not use lotion on legs for 48 hours before surgery.
2. Travel: We recommend patients not fly or travel long distances by car for 1-2 weeks after treatment.
3. Shaving: Legs should not be shaved for 72 hours before surgery to avoid possible skin infections.
4. Medications: Please take all of your medications on the morning of surgery, just as you would do on any other day.
5. Blood thinning medication: Patients taking **Plavix** (clopidogrel) should stop five days prior to surgery. Please consult your cardiologist prior to stopping this medication.

Patients taking **aspirin** should stop ten days prior to surgery.

Patients on **Coumadin** (warfarin) do not need to stop this medication.

All patients with a prior history of deep vein clot should receive a pre op injection of Lovenox. Please call our office if this pertains to you.

Day of surgery: Wear sweatpants or other loose fitting clothing to accommodate your dressings. Wear comfortable shoes since you will be required to walk near the office for 20-30 minutes after surgery. Please eat a light breakfast prior to your procedure.

Follow-up: You will be seen 24-48 hours after your surgery to remove your surgical dressings. Patients undergoing endovenous radiofrequency ablation will also have an ultrasound of the treated leg at that time. If desired, patients are also seen two weeks after their procedure for a quick check of leg healing and to answer any questions.

Pre-op appointment: _____

Surgery day/date: _____

Arrival time: _____

1st post-op appointment:_____

ECA appointment _____

Pre-op appointment: _____

Surgery day/date: _____

Arrival time: _____

1st post-op appointment:_____

ECA appointment _____

Please anticipate being here for about 1.5-3 hours on the day of your procedure. This will cover your preparatory time, procedure time, and walk afterwards. Appointment times may vary slightly, your time will be confirmed the day prior to your procedure.

Please arrive on time for your procedure(s), late arrivals may be rescheduled. If you need to cancel or reschedule your procedure(s), please call the office at the above number. Procedures must be cancelled or rescheduled 2 weeks prior to scheduled appointment to avoid a $250 procedure cancellation fee.

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Postoperative Instructions

Bandages/Dressings: Following surgery your leg will be wrapped with gauze, then covered with your compression stockings. Please leave these dressings in place until we remove them 24 hours after surgery.

Stockings: Compression stockings are crucial to the success of your treatment. Their proper use will result in less pain and a better outcome. They will be worn for 3 weeks total and should be worn as follows:

1. First two days: Two stockings on the treated leg in the daytime, one stocking at night. *You will never sleep with two stockings on one leg.*
2. Days 3-21: One stocking on the treated leg in the daytime, no stocking at night.

Pain: The best way to describe the postoperative pain is "sore." Pain is worst the first few days and again at the one week mark. Most pain should be gone by two weeks. Your legs will also be bruised. If your leg hurts, check your stockings. Pain will result if the stocking slides down and bunches behind the leg or if there is any fold or crease in the stocking. Any pain in the foot is from the stockings. Walking also resolves most pain. Take 600mg of Ibuprofen every 6-8 hours (with food) as needed for pain. Apply Arnica gel to the leg as often as you please (most patients do it just twice a day) as this will soothe the leg and help resolve the bruising. You may notice little lumps or bumps under the tiny incisions where we removed bulging veins. This is normal and will disappear in 8-12 weeks.

Activity: Normal activity can be resumed immediately, but strenuous exercise can cause the vein to reopen, so please avoid vigorous activity and weight lifting >50 lbs for 14 days. Showers are okay, but sitting in hot baths or hot tubs should be avoided for 14 days. You must walk at least 30 minutes daily after surgery.

Concerns: As with any procedure, problems can develop. If you develop a fever (more than 101.5 F or 38.5 C) or severe worsening pain/swelling, please call our office at (212) 371-8460.

Follow-up: All patients are seen 24-48 hours after surgery and again 6 weeks after surgery for a repeat ultrasound to investigate if further treatment is necessary.