INNOVATIVE MEDICAL ASSOCIATES

9675 BRIGHTON WAY · SUITE 380 · BEVERLY HILLS · CA · TEL 310.281.4999 · FAX 310.275.8727

Dear Patient

We thank you for choosing us to participate in your medical care. We take pride in providing world class medical services to individuals and families.

Our promise is: "We listen, we care and we follow through." Our offices will care for you with a holistic approach with an awareness of your physical, psychological and emotional needs. Medical care will be tailored to provide prevention, early detection and treatment of illnesses. We will make every attempt to heal each person.

Our office systematized so the work is done in the same professional manner. You will have a pleasant experience through services delivered with compassion. As a patient, you will be seen on time - every - time as promised by qualified staff. We will offer yearly physical examinations which includes complete history and physical exams, blood test, ECG's, stress test and ultrasound, echo cardiogram, carotid duplex, aortic aneurysm detection, bone density tests - all non-invasive, for early detection of illnesses.

Dr. Arman Hekmati is a Board Certified Internist. He completed his education at University of Virginia and Medical College of Virginia and his internship and residency at Los Angeles County University of Southern California Medical Center. He has served as Assistant Professor of Medicine and attending Physician at LAC-USC Medical Center and is currently the President of Foundation for Healthy Living which has been created by him for improving the health and lives of individuals. He has medical staff privileges at St. John's Hospital & Health Center, Cedars-Sinai Medical Center and UCLA Medical Center.

Appointments

Our office is open from 8:30 a.m. to 5:30 p.m. Monday through Friday. Please call during these hours for appointments. If an emergency should arise outside of regular hours, you will be connected to our answering service who will notify Dr. Hekmati or the doctor on-call. If you are unable to keep your appointment, please notify us at least 24 hours before the appointment.

Prescription Refills

Please call your pharmacist and have him fax your prescriptions to our office at 310-275-8727 during office hours to insure prompt service. Please anticipate your needs prior to holidays, evenings, or weekends by having your pharmacist contact our office before. Prescriptions may not be refilled, however, if a patient has failed to keep the follow-up visit. This policy is enforced for the protection of the patient.

Fees, Insurance Billing, and Payment Policies

All services rendered to patients are charged directly to the patient and the patient/ guarantor is personally responsible for payment. We will be happy to file insurance claims within two weeks of visit on your behalf and payment comes directly to you. Certain payments may not be covered within benefits of your insurance. They may include a phone consultation with the patient or family members, consultations with other health care providers, preventive medicine services, individual counseling, physical examinations, injections, family meetings, extra office time, email correspondence and travel time.

All accounts that go beyond 90 days past due will incur interest at the rate of 1.5% per month and transferred to collection for accounts receivable. Should this be necessary, an additional collection fee may be added to your account.

We accept major Credit Cards, Checks and Cash.

Name ______________________________________ Date ________________

Signature ______________________________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires individually identifiable health information used or disclosed by us, whether electronically on paper, or orally, be kept properly confidential. HIPAA gives the patient significant new right to understand and control how health information is used. It also provides penalties for covered entities that misuse personal health information. We may use and disclose your medical records only for the following purposes:

- Treatment　Providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment　Obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations　Conducting quality assessment and improvement activities, auditing cost -management analysis, and providing customer service .

We may also create and distribute de-identified health information by removing all individually identifiable information. We may contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits and services, which might of be interest to you. Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization. You have the following rights, which you can exercise by presenting a written request to our office.

- To request restrictions on certain uses and disclosures of protected health information. This include disclosures to family members, other relatives personal friends,or other persons identified by you. We are not required to agree to requested restrictions. However,if we do agree to a restriction, we are obligated to abide by it unless you agree in writing to remove it.
- To a reasonable request to receive confidential communications from us by alternative means or alternative locations.
- To inspect and copy your protected health information
- To amend your protected health information
- To receive an accounting of disclosures of protected health information
- To obtain a paper copy of this notice upon request

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised Notice of Privacy Practices from this office.Should you feel your privacy protections have been violated, you may file a written complaint, about violations of the provisions of this notice or of the policies and procedures of our office, with this office or with the Department of Health & Human Services, Office of Civil Rights (address below). We will not retaliate against you for filing a complaint. Please contact us for more information. For more information about HIPAA contact: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Ave., SW, Washington, D.C. 20201. PHONE: (202) 619-0257 or toll free (877) 696-6775.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the usesand disclosure of my health information. I understand that your office has the right to change its Notice of Privacy Practices from time to time and that I may contact your office at any time to obtain a current copy of the Notice of Private Practices.I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name ____________________________　　　　Date ______________

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PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Last Name ______________________ First Name ______________________ MI ____________

Home Address ______________________ City ______________ State ________ Zip __________

Phone: Home ______________________ Work ______________ Cell ______________________

Email Address: ______________________ Referred by ______________________________

Employer Name & Address ____

Occupation ______________________ Marital Status: SINGLE__ MARRIED__ WIDOW__ DIVORCED__

Social Security No. ______________________ Drivers License Number ______________ State ________

Place of Brith ______________________ DOB ______________ Age ______ Sex: M — F —

In case of an emergency who can we contact ______________________________________

Phone ______________________ Relationship ______________________________

Primary Ins. Co. ____

Policy Holder Last Name ______________________ First Name ______________________ MI ____________

Date of Birth ______________________ Social Security No. ______________________________

Employer's Name, Address & Phone ____

Policy No. ______________________ Group No. ______________ Relationship ____________

Secondary/ Supplemental Ins Co. ____

Policy Holder Last Name ______________________ First Name ______________________ MI ____________

Employer's Name, Address & Phone ____

Subcriber No. ______________________ Group No. ______________ Relationship ____________

Responsible party for payment

Last Name ______________________ First Name ______________________ MI ____________

Date of Birth ______________________ Social Security No. ______________ Drivers Lic. # ____________

Address ______________________ City ______________ State ________ Zip __________

Phone ______________________ Work ______________ Cell ______________________

Relationship ____

I HEREBY AUTHORIZE ARMAN HEKMATI, M.D. TO FURNISH TO MY INSURACE COMPANY WITH WHICH MY CASE IS INVOLVED, ALL INFORMATION WHICH THE SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY ILLNESS OR INJURY. I UNDERSTAND THAT AS A COURTESY MY PRIMARY INSURANCE AND SUPPLEMENTAL INSURANCE COMPANY WILL BE BILLED FOR MEDICAL AND/ OR HOSPITAL INCURRED EXPENSES. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SAID DOCTOR FOR CHARGES NOT COVERED BY MY INSURANCE AND BILLS ARE DUE UPON RECEIPT. SHOULD SAID BALANCE NOT BE PAID WHEN DUE, LATE CHARGES WLL BE IMPOSED IN THE AMOUNT OF 1 1/2 % INTEREST PER MONTH FROM THE ATE OF MY LAST TREATMEN. IT IS ALSO UNDERSTOOD THAT THE GUARANTOR (IF ANY) AGREES TO REMAIN RESPONSIBLE TO THE SAID DOCTOR FOR ANY AND ALL CHARGES DUE AND OWING. A PHOTOCOPY OF THIS ASSIGNMENT IS AS VALID AS THE ORIGINAL. IN CASE THIS IS SENT FOR COLLECTION I WILL BE RESPONSIBLE FOR A $20.00COLLECTION FEE, INTEREST, ATTORNEY, AND COURT COSTS.

Patient's Signature ______________________ Date ____________

Guaranator's Signature ______________________ Date ____________

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INITIAL VISIT QUESTIONAIRE

First Name ____________ Last Name ____________ Date of Birth ____________

Address ____________ City ____________ State ________ Zip ________

Phone No ____________ Sex: M — F —

Who filled out this form? ____________

Relationship, if other than patient? ____________

Who has been your primary doctor?

First Name ____________ Last Name ____________ Phone No ____________

Fax No ____________ Address ____________

City ____________ State ________ Zip ________ Country ____________

Do you plan to continue to be followed by this doctor?.

- ◯ Yes ◯ No ◯ Not Sure

Which of the following best describes your residence? (check one)

- ◯ Own house or condo
- ◯ Rent house, condo or apartment
- ◯ Live with other in their home, condo or apartment
- ◯ Retirement Hotel
- ◯ Board and care, Residential Care Facility
- ◯ Other, specify

Are you currently (check one)

- ◯ Married
- ◯ Divorced/ Separated
- ◯ Widowed
- ◯ Single/ Never Married

With whom do you live?

- ◯ Alone
- ◯ Spouse or partner
- ◯ Child or other family
- ◯ Others, not family
- ◯ Other, specify ____________

Are you currently (check one).

- ◯ Retired
- ◯ Working at least part-time
- ◯ Looking for work
- ◯ Other, specify ____________

How much school did you complete? (check one).

- ◯ Less than 6th grade
- ◯ Less than high school graduate
- ◯ High School graduate
- ◯ Some College
- ◯ College Graduate
- ◯ More than college graduate

Do you have a medical Durable Power of Attorney?

- ◯ Yes
- ◯ No

Do you have a living will?

- ◯ Yes
- ◯ No

Have any members of your family had any of the following conditions? (check all that apply)

- ◯ Dementia or Alzheimer's Disease
- ◯ Cancer, of what? ____________
- ◯ Heart Disease
- ◯ Stroke
- ◯ Diabetes
- ◯ Depression
- ◯ None of these

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Gather all your prescription and non-prescription medicines (pills, capsules, eye drops, nasal sprays, ointments for your skin, aspirin, laxatives, calcium, supplements, vitamins, etc.), everything that you sused at least twice in the last year. Separate those that you use regularly (even once a week) from those that you use only as needed.

I. List all medicines that you use regularly at this time.

Current Medications	What strenght?	How do you use it? (How many? How many times a day?)

II. List medicines that you used " as needed" at least twice in the last year. (Any medicines used daily or even weekly should be listed above.)

Medications used "as needed" at least twice in the last year.	How often? (weekly/ monthly)	How do you use it? (How many? How many times a day?)

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To be certain that we have covered everything, during the last three months, have you had any of the following symtons or problems? (check all that apply)

I. EYE OR EAR PROBLEMS
- ◯ Visual or eye problems
- ◯ Hearing difficulty or ear trouble

II. HEART PROBLEMS
- ◯ Chest pain or tightness
- ◯ Rapid or irregular heart beat

III. LUNG PROBLEMS
- ◯ Persistent cough
- ◯ Difficulty breathing or shortness of breath

IV. DIGESTION PROBLEMS.
- ◯ Dental Problems
- ◯ Difficulty swallowing
- ◯ Frequent indigestion or stomach ache
- ◯ Frequent nausea or vomiting
- ◯ Change in bowel habits
- ◯ Weight loss. How many lbs?
- ◯ Black bowel movement or bleeding from rectum
- ◯ Frequent diarrhea
- ◯ Persistent constipation

V. BONE & JOINT PROBLEMS
- ◯ Leg pain on walking
- ◯ Back or neck pain
- ◯ Joint pain or stiffness
- ◯ Foot problems

VI. BRAIN & NERVOUS SYSTEM
- ◯ Frequent headaches
- ◯ Frequent dizzy spells
- ◯ Passing out or fainting
- ◯ Paralysis, leg or arm weakness
- ◯ Numbness or loss of feelings
- ◯ Serious problem with memory or difficulty thinking
- ◯ Tremor or shaking

VIII. KIDNEY & URINARY TRACT PROBLEMS
- ◯ Urination at night
- ◯ Frequent urination
- ◯ Painful urination
- ◯ Difficulty starting or stopping urination
- ◯ very dissatisfied

VII. GYNECOLOGY PROBLEMS
- ◯ Vaginal bleeding after you stopped having your period
- ◯ Breast lumps or discomfort
- ◯ Vaginal discharge

IX. OTHER HEALTH PROBLEMS
- ◯ Difficulty with sleeping
- ◯ Falling or stumbling
- ◯ Swelling feet or ankles
- ◯ Fever or sweats
- ◯ Other, please specify:

☐ CHECK HERE IF YOU HAVE NOT HAD ANY OF THESE PROBLEMS DURING THE LAST 3 MONTHS.

During the past 12 months, have you ever lost your urine or gotten wet?

◯ Yes ◯ No

If yes, have you lost urine on at least six separatedays?

◯ Yes ◯ No

If Yes, when did you have your most recent sigmoidoscopy or colonoscopy? (year) ☐

Have you ever had an examination of your bowel with a scope (sigmoidoscopy or colonoscopy)?

◯ Yes ◯ No

Do you have any drug allergies?.

◯ Yes ◯ No

DRUG	REACTION

List Surgeries (operations)

DATE	SURGERY (OPERATIONS)

List other hospitalizations

DATE	HOSPITAL	REASON

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Do you drink alcohol, including bear and wine? (check one)

- ◯ Daily
- ◯ Greater than 3 times a week
- ◯ Less than 1 time a week
- ◯ Never

Have you ever smoked cigarettes?

- ◯ No
- ◯ Yes - If Yes, Are you now smoking?
- ◯ No. If no,
- ◯ Yes. If yes,

For how many years did you smoke? ______________

How much did you smoke? Packs per day ______________

How many years have you smoked? ______________

How many years ago did you quit? ______________

How much did you smoke? Packs per day ______________

QUESTIONS FOR WOMEN ONLY

Do you perform breast self-exam (BSE) at least once a month?

◯ Yes ◯ No

Have you ever had a mammogram?

◯ Yes ◯ No

If Yes, have you had a mammogram within the last 2 years?

- ◯ Yes - If yes, when was your last Pap Smear?
- ◯ No

Do you have any other health problems that you would like your doctor to know about before your visit?

We want to know if you need help with any of the following, and who helps you. Please fill out each task .

Task	DON'T NEED HELP	NEED HELP	IF YOU NEED HELP, WHO HELPS? (Name & Relationship)
Feeding yourself	☐	☐	
Getting from bed to	☐	☐	
Getting to the toilet	☐	☐	
Getting dressed	☐	☐	
Bathing	☐	☐	
Using the telephone	☐	☐	
Taking your medicine	☐	☐	
Preparing meals	☐	☐	
Managing money/ Financial Affairs/ Checkbook	☐	☐	
Doing Laundry	☐	☐	
Housework	☐	☐	
Shopping for groceries	☐	☐	
Driving	☐	☐	
Doing "handyman"	☐	☐	
Climbing a flight of	☐	☐	
Getting to places beyond walking distance	☐	☐	

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Do you employ someone to provide care or help you in your home?

◯ No ◯ Yes. If yes, how many hours a day and how many days a week is your paid helper available for you?

Hours a day ____________ Days a week ______________

Is this sufficient to meet your needs?

◯ No ◯ Yes

Do you get help from a family member or friend in your

◯ No ◯ Yes - If yes, How many hours a day and how many days a week is your family member or friend available for you?

Hours a day ______________ Days a week ______________

Is this sufficient to meet your needs?

◯ No ◯ Yes

Do you provide care for a family member?

◯ No ◯ Yes

PAST MEDICAL HISTORY

Which medical conditions do you have or have you had in the past?

I. EYE & EAR PROBLEMS

◯ Cataracts

◯ Glaucoma

◯ Macular degeneration of the eye

◯ Hearing loss/ Hearing aid

◯ Other, specify:______________________

II. HEART PROBLEMS

◯ Angina

◯ Heart Attack

◯ Heart Failure

◯ High Blood Pressure

◯ IIrregular heart beat

◯ Other, specify: ______________________________

III. LUNG PROBLEMS

◯ Asthma

◯ Bronchitis

◯ Emphysa

◯ Other, specify:________________

IV. BONE & JOINT PROBLEMS

◯ Arthritis

◯ Osteoporosis

◯ Fractured hip

◯ Fractured spine

◯ Gout

◯ Other, specify:__________________

V. GLAND PROBLEMS

◯ Diabetes

◯ Thyroid overactive (high)

◯ Thyroid underactive (low)

◯ Other, specify:_________________________

VI KIDNEY & URINARY TRACT PROBLEMS.

◯ Kidney Disease

◯ Prostate Disease

◯ Frequent bladder or urinary tract infection

◯ Other, specify:______________________________

VII. GASTROINTESTINAL PROBLEMS

- ◯ Ulcers
- ◯ Heartburn/ Hiatal hernia
- ◯ Diverticulosis
- ◯ Liver disease/ Cirrhosis
- ◯ Hepatitis
- ◯ Polyps
- ◯ Gallbladder disease
- ◯ Other, specify: ______________________

VIII. NERVOUS SYSTEM PROBLEMS

- ◯ Stroke
- ◯ Demential/ Alzheimer's disease
- ◯ Parkinson's disease
- ◯ Epilepsy/ Seizures
- ◯ Other, specify:

IX. OTHER HEALTH PROBLEMS

- ◯ Anemia
- ◯ Hernia
- ◯ Thrombosis (blood clots)
- ◯ Cancer
- ◯ Depression
- ◯ Sexual function problems
- ◯ Other, specify: ______________________________________

☐ Check if you do not know or do not have any of these problems

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AUTHORIZED TELEPHONE NO. & ADDRESSES AND/ OR INDIVIDUALS FOR RELEASING PATIENT HEALTH INFORMATION

Dear Patient: Please list which telephone numbers and/ or addresses we can contact you if we need to discuss your appoinment / medications / medical care/ medical bill with you:

- ☐ Home No. ____________________
- ☐ Work No. ____________________
- ☐ Cell No. ____________________
- ☐ Page No. ____________________
- ☐ Fax ____________________
- ☐ Email ____________________

Last Name ____________ First Name ____________ Address ____________________

City ____________ State ________ Zip ________

Last Name ____________ First Name ____________ Address ____________________

City ____________ State ________ Zip ________ Relationship[____________________

Phone ____________________

☐ Appointments ☐ Medications ☐ Medical Care ☐ Medical Bill

Patient's Name ____________________ Date ____________

Patient's Signature ____________________