The Center for Cholesterol Management

A Medical Corporation

NAME Shahriar Abachi

DATE 9/25/09

DOB = 8/12/51

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

pt does not want to be seen because he does not believe the lab results. He thinks that they are wrong

PMHX:

9/25/09

PSHX:

NAME

MEDS:

ALLERGIES:

SOCIAL HISTORY:

FAMILY HISTORY:

REVIEW OF SYSTEMS:

NAME

PHYSICAL EXAM

BP=124/71 P=70 RR T

GENERAL:

HEENT:

NECK:

CHEST:

HEART:

ABDOMEN:

BACK:

EXTREMITIES:

NEURO:

Assessment

PLAN:

NMR LIPOPROFILE®

LipoScience, Inc.
2500 Sumner Boulevard
Raleigh, NC 27616
877-547-6837
www.liposcience.com

Page 1

Patient Name	Sex	Age
ABACHI,SHASHRIAR	M	58

Patient ID	Birth Date	Accession Number
15981134	08/02/1951	T0510703

Clinician: RICHMAN,MICHAEL

Client Name and Address:
Center for Cholesterol Mgmt 15057/
1950 Sawtelle Blvd Suite 150
Los Angeles, CA 90025
Phone: (310)481-3939
FAX: (310)481-3949

Date Collected	Date Received	Report Date and Time	Requisition Number	Fasting Status
09/18/2009	09/22/2009	09/22/2009 22:46	15981134	NON-FASTING

LDL PARTICLE NUMBERS

	nmol/L	Optimal	Near or above optimal	Borderline-high	High	Very High
LDL-P (LDL Particle Number)	**2608**	<1000	1000-1299	1300-1599	1600-2000	>2000

	nmol/L	Low	Moderate	Borderline-high	High
Small LDL-P	**2367**	<600	600-849	850-1200	>1200

PATIENT GOALS

High-Risk Patients
-primary goal: LDL-P<1000 nmol/L
-secondary goal: small LDL-P<850 nmol/L

Moderately High-Risk Patients
-primary goal: LDL-P<1300 nmol/L
-secondary goal: small LDL-P<850 nmol/L

LIPIDS

	mg/dL	Optimal	Near or above optimal	Borderline-high	High	Very High
LDL-C (calculated)	**150**	<100	100-129	130-159	160-189	>=190

HDL-C mg/dL: **38** — Desirable >=40

Triglycerides mg/dL: **308** — Desirable <150

Total Cholesterol mg/dL: **250** — Desirable <200

LDL-C is inaccurate if patient is nonfasting.

METABOLIC SYNDROME MARKERS

These markers increase the risk of developing Type 2 Diabetes Mellitus.

	nm	Large (Pattern A)	Small (Pattern B)
LDL Particle Size	**19.7**	23.0 - 20.6	20.5 - 18.0

	µmol/L	Low Risk	Intermediate	High Risk
Large HDL-P	**4.6**	>9.0	4.0 - 9.0	<4.0

	nmol/L	Low Risk	Intermediate	High Risk
Large VLDL-P	**11.5**	<0.5	0.5 - 5.0	>5.0

Small LDL Size (≤20.5 nm)	✓	Low Large HDL-P (<4.0 µmol/L)		High Large VLDL-P (>5.0 nmol/L)	✓

** Continue **

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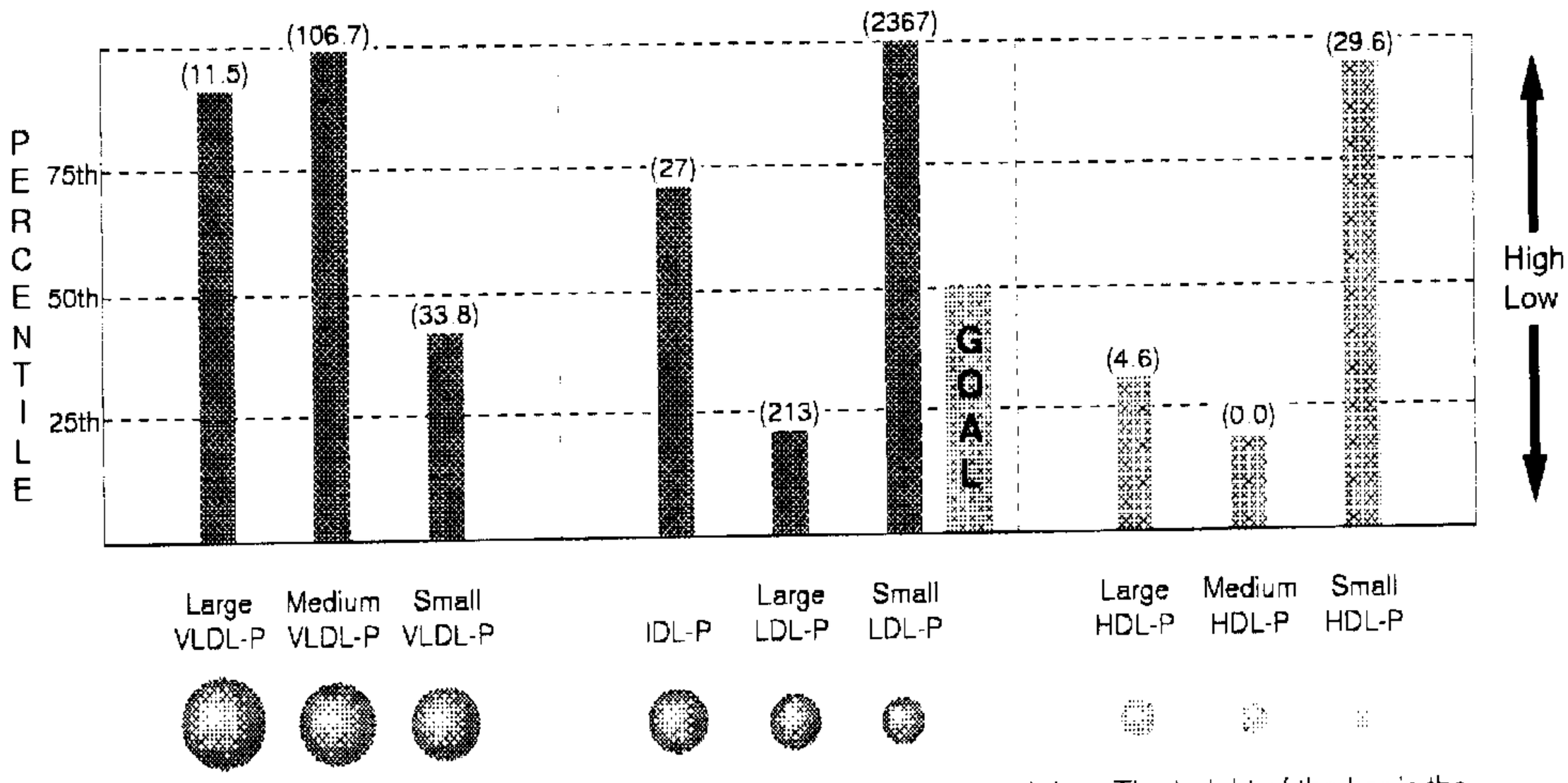
Patient Name	Accession Number	Requisition Number	Report Date and Time
ABACHI,SHASHRIAR	T0510703	15981134	09/22/2009 22:46

SUBCLASS PARTICLE NUMBERS



Lipoprotein subclass particle numbers are given in parentheses above each bar. The height of the bar is the percentile indicating if the value is "high" or "low" based on a reference population consisting of >6,900 subjects enrolled in the Multi-Ethnic Study of Atherosclerosis (MESA).

PRACTITIONER'S NOTES

2500 Sumner Blvd. • Raleigh, NC 27616
(919) 212-1999 • FAX: (919) 212-1954
CLIA #34D0952253

LipoScience

1: 31134

Y
r For Cholesterol Mgmt 15057
Sawtelle Blvd
te 150
s Angeles, CA 90025
310)481-3939 Fax: 13104813949

All information must be completed for sample to be processed

Social Security Number | Patient ID/Medical Record Number

ABAchi Shashriar
Last Name | First Name | Middle

1011 11th st. # 227.
Address

Santa Monica CA 90403.
City | State | Zip

Date of Birth 8/2/51 (mm/dd/yy) ☒ Male ☐ Female

Telephone

IF PATIENT IS NONFASTING CHECK HERE ☑

Insurance (REQUIRED) Attach copy of insurance card (front & back)

☐ Medicare ☐ Insurance ☒ Client ☐ Patient

Medicare Number (including suffix)

BCBS ID Number (including prefix)

Insurance Company Name

Insured Name | Employer Name/Employer#

Member/Insured ID# | Group#

Claims Address

City | State | Zip

Patient Relation to Insured ☐ Self ☐ Spouse ☐ Dependent

Designate Requesting Clinician

[ ] 1972554806 RICHMAN, MICHAEL F
[ ] 1073557294 UYEDA, ROBERT Y

Additional Clinician: NPI

Collection Date 9/12/09 (mm dd yy) Collection Time 12:10 Pm

ICD-9 Code(s) (MANDATORY)

272.9

Patient/Responsible Party Signature: I hereby authorize the release of medical information to LipoScience for services as described herein and authorize payment directly to LipoScience. I agree to assume responsibility for payment of charges for laboratory services that are not covered by the healthcare insurer.

X [signature] 9-18-09
Patient/Responsible Party Signature | Date

CUSTOM PROFILES

[ ] 1040 Dr Richman's Initial Panel

PROFILES					
220 ☒ *NMR LipoProfile®* (includes CPT codes 83704 + 80061)	P or S	180 ☐ Cholesterol, Total	P or S	100 ☐ Lp(a)	P or S
375 ☐ *NMR LipoProfile®+Homocysteine+CRP* (includes CPT codes 83704 + 80061 + 83090 + 86141)	P or S	245 ☐ Creatine Kinase (CK), Total	P or S	410 ☐ TSH	S
540 ☐ *Lipoprotein Quantification by NMR with TC* (includes CPT codes 83704 + 82465)	P or S	125 ☐ CRP-High Sensitivity	P or S	420 ☐ T-4, Free	S
		178 ☐ Glucose	OX	430 ☐ T-4, Total	S
INDIVIDUAL TESTS		179 ☐ Glycohemoglobin (A1c)	L	185 ☐ Triglycerides	P or S
140 ☐ ALT	P or S	190 ☐ HDL Cholesterol	P or S	**COLLECTION**	
150 ☐ AST	P or S	110 ☐ Homocysteine	P or S	P = 4 ml Plasma, Lavender Top Tube	
170 ☐ C-Peptide	S	160 ☐ Insulin	S	S = 4 ml Serum, Red Top Tube or Greiner gel tubes* * No other gel tubes are acceptable	
		195 ☐ LDL Cholesterol, Direct Method	P or S	P or S = Plasma or Serum Acceptable	
		210 ☐ Lipid Panel, Chemical Method	P or S	L = Whole Blood, Lavender Top Tube	
		301 ☐ Lipoprotein Quantification by NMR	P or S	OX = Whole Blood, Gray Top (oxalate/fluoride) Tube	

Please see the CMS policy for specific limits regarding the frequency of lipid testing.

15981134 15981134 15981134 15981134

Collection, Storage, and, Shipping Instructions on Back

ATTACH ABN IF NECESSARY

Specimen ID Labels #1

White Copy - LipoScience
Yellow Copy - Client

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: Shahriar Abachi DATE: 09/17/09

SEX: (M) F DOB: 08/12/51 SSN: 545-43-6146 DL#: N5692717

ADDRESS: 1011 11th st. #427

CITY: Santa Monica STATE: CA ZIP: 90403

FAX: _____ EMAIL: seanzAC@yahoo.com PHONE: (310)699-5435

EMERGENCY CONTACT: Akhtar Abedi PHONE: (310)395-8492

ADDRESS: 1011 11th st #427

CITY: Santa Monica STATE: CA ZIP: 90403

EMPLOYER: CSULB PHONE: _____

ADDRESS: Longbeach CITY: Long Beach STATE: CA ZIP: 90815

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
Tonsils removed	1960	

Have you ever smoked? ☒ Yes ☐ No **How many cigarettes per day?** 20

How long (have) did you smoke (d)? 15 y

If you quit, when did you quit? 15 years ago

How many glasses per week do you consume of? WINE 0 **BEER** 0 **COCKTAILS** 0

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

	WHICH FAMILY MEMBER	HOW OLD WERE THEY
Cancer	X	
Heart Attack	grand mother	
Angina or clogged arteries	mother	
Sudden death	X	
Hypertension	mother	
Other heart disease		

High cholesterol ______ X ______

Stroke ______ X ______

Diabetes ______ X ______

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? EKG (normal)

When where they done? ______

After any problems you wish to address at this visit?

______

[signature] ______ 09/17/09

Patient name (sign) Date

______ ______

Witness Date

INSURANCE INFORMATION

Please provide us with your medical insurance information:

PRIMARY INSURANCE POLICY:

Company: Kaiser 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 DDIECTLY TO THE ASSIGNEE AT 1950 SAWTELLE BLVD # 145A LOS ANGELES, CA 90025.
IN 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 AN MY MEDICAL CARRIER, AND THAT FINANCE CHARGES WDLL 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.

09/17/07

Your signature here — Today's 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: 09/17/09

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

X

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

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, The Center for Cholesterol Management may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to The Center for Cholesterol Management's Notice of Privacy Practices (NOPP) for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices (NOPP) prior to signing this consent. The Center for Cholesterol Management reserves the right to revise its Notice of Privacy Practices (NOPP) at anytime. A revised NOPP may be obtained by forwarding a written request to The Center for Cholesterol Management at the address above.

With my consent, The Center for Cholesterol Management may call my home, office, and/or other locations and leave a message on voicemail, answering machine and/or directly reference me and/or any items that assist The Center for Cholesterol Management in carrying out TPO, such as appointment reminders, insurance items, lab reports, hospital reports, etc.. I agree that any such call or message pertaining to my clinical care, including laboratory results may reference me personally by name.

With my consent The Center for Cholesterol Management may mail to my home and/or other locations, items that assist The Center for Cholesterol Management to carry out TPO, such as appointment reminder cards, practice marketing brochures, patient statements, etc., as long as they are marked personal and/or confidential.

With my consent, The Center for Cholesterol Management may e-mail to my home and/or other locations as per the patient data sheet. I have the right to request that The Center for Cholesterol Management restrict how it uses or discloses my PHI to carry out TPO. However, The Center for Cholesterol Management is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the aforementioned uses as well as The Center for Cholesterol Management's use and disclosure of my PHI to carry out TPO. I have received a copy of The Center for Cholesterol Management's Privacy Practices Policy (NOPP). I may revoke my consent in writing except to the extent that The Center for Cholesterol Management has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, he Center for Cholesterol Management may decline to provide treatment to me

Signature of patient or legal guardian: X
Date: 07/17/09
Patient's Name: Shahriar Abacchi
Witness:

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.

Starting January 2001, you will also need to complete a separate form, "Privacy of Medical Records," so that we have a clear understanding of those individuals and parties whom you intend to have access to information contained in your medical record, and those whom you do not.

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: 09/17/09

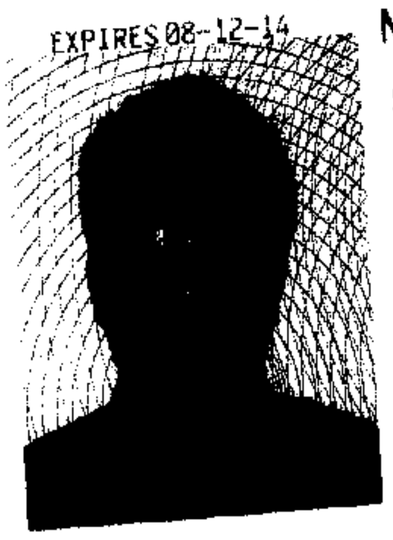
DMV CALIFORNIA DMV

DRIVER LICENSE

CLASS: C M1

N5692717

EXPIRES 08-12-14



SHAHRIAR ABACHI
1011 11TH ST APT 227
SANTA MONICA CA 90403

SEX:M HAIR:BRN
HT:5-11 WT: 190

RSTR: CORR LENS

EYES:BRN
DOB: 08-12-51

08/31/2009 616 12 FD/14