A Medical Corporation

Center For Cholesterol Management

NAME Yossi Abitbul

DOB 10/03/1976

DATE 4/28/10

HISTORY OF PRESENT ILLNESS

Yossi comes in today for follow up
He is doing very well and has
no c/o.

PMHX

5 Δ

Metabolic Syndrome Criterion
(Presence of 3 or more criterion define Metabolic Syndrome)

1 Waist > 40" 35" M/F
Waist > 35"/32" (M/F Asian

2 HDL-C < 40/50mg/dL (M/F)

3 TG > 150 mg/dL

4 FBS > 100 mg/dL or DM

5 BP > 130 /> 85 (or on medication)

Laboratories

CMP-wnl 906 4/21/10

MEDS

NAME

PHYSICAL EXAM

BP 112/69 . P 72 RR 16 T 98

GENERAL WDWN O'in NAD

CHEST clear

HEART RRR

ABDOMEN abd- soft, NT

EXTREMITIES WARM.

ASSESSMENT 33yo Dsmelio c stemi/nuclg hc CAD c/b atenol LMP

PLAN

- O2 FA
- T/u lytes

The Center for Cholesterol Management

A Medical Corporation

NAME Yossi Abitbul

DOB 10/03/1976

DATE 4/21/10

CHIEF COMPLAINT: -

32 yo Israeli ♂ c a strong family h/o CAD presents for lipid mgmt.

HISTORY OF PRESENT ILLNESS:

pt denies chest pain c SOB
ϕ MI ϕ CVA.
he doesn't get much exercise
never had a stress test

PMHX: -

① ↓ HDL-C

PSHX: -

ϕ

NAME

abitbul

MEDS:

ϕ

ALLERGIES: - NKDA

SOCIAL HISTORY: -

ϕ tobacco

FAMILY HISTORY:

cancer

MI

REVIEW OF SYSTEMS:

NC/AT

NAME

abrithm

PHYSICAL EXAM

BP 112/70 P 74 RR 16 T 98

GENERAL: WDWN ♂ WM NAD

HEENT: NC/AT

NECK: ø JVD

CHEST: clear

HEART: RRR

ABDOMEN: soft, NT

BACK:

EXTREMITIES: WWW

NEURO:

Assessment 33yo Israeli ♂ c strong family h/o CAD presents for lipid mgmt

PLAN:

① NMR
② 7/4/week

3

WESTERN HEALTH SCIENCES
MEDICAL LABORATOI

21018 Osborne St. • Canoga Park, CA 91304
2 Phone (818) 773-9771 • (800) 287-9771
Directors: Arnold Channing, M.D.
Richard J. Vance, C.L.B.

CLIENT NAME
MICHAEL RICHMAN, M.D.
1950 SAWTELLE #150
LOS ANGELES, CA 90025
(310)481-3939
PT PHONE: ( ) -

PATIENT
ABITBUL, YOSSI
DOB: 10/03/76

AGE SEX
33 M

DATE RECEIVED	DATE DRAWN	DATE REPORTED	ACCESSION NO.
04/21/10	04/21/10	04/22/10	3073278

LABORATORY REPORT

** COMPLETE REPORT **

TEST	RESULTS IN RANGE	RESULTS OUT OF RANGE	UNITS	REFERENCE RANGE
COMPLETE BLOOD COUNT	.....			
WHITE BLOOD COUNT	5.3		thou/mm3	4.4-11.0
RED BLOOD COUNT	5.61		mil/mm3	4.70-6.10
HEMOGLOBIN	17.0		g/dL	14.0-18.0
HEMATOCRIT	48.9		%	42.0-52.0
MCV	87		fL	84-98
MCH	30.3		pg	28.0-33.0
MCHC	34.7		%	32.0-36.0
RDW	11.2		%	10.6-14.7
PLATELET COUNT	160		thou/mm3	150-450
MPV	9.0		fL	5.1-10.7
DIFFERENTIAL WBC	.....			
NEUTROPHILS	60.0		%	40.0-75.0
MONOCYTES	6.9		%	0-10.0
LYMPHOCYTES	31.0		%	20.0-40.0
EOSINOPHILS	1.4		%	0.0-5.0
BASOPHILS	0.8		%	0.0-2.0
	WBC, RBC, AND PLATELET HISTOGRAMS APPEAR NORMAL.			
COMP METABOLIC PANEL	.....			
SODIUM	143		mEq/L	135-149
POTASSIUM	4.9		mEq/L	3.4-5.4
CHLORIDE	103		mEq/L	98-108
CARBON DIOXIDE	29		mEq/L	22-32
CALCIUM	10.2		mg/dL	8.5-10.5
GLUCOSE	75		mg/dL	<100
BLOOD UREA NITROGEN	14		mg/dL	6-25
CREATININE	1.0		mg/dL	0.6-1.5
BUN:CREATININE RATIO	14		ratio	10-28
TOTAL PROTEIN, SERUM	7.7		g/dL	6.0-8.2
ALBUMIN, SERUM	4.9		g/dL	3.5-5.1
GLOBULIN	2.8		g/dL	2.0-3.5
A:G RATIO	1.8		ratio	1.0-2.2
BILIRUBIN, TOTAL	0.6		mg/dL	0.0-1.2
ALKALINE PHOSPHATASE	64		U/L	33-141
SGOT/AST	18		U/L	6-36
SGPT/ALT	15		U/L	<48

4/28/10

LIPOSCIENCE

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

Patient Name	Sex	Age
ABITBUL, YOSSI	M	33

Patient ID	Birth Date	Accession Number
16154201	10/03/1976	H0556379

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
04/21/2010	04/22/2010	04/23/2010 06:32	16154201	FASTING

NMR LipoProfile® test

Reference Range[1]

	Percentile[1]	nmol/L	Low (20th)	Moderate (20th–50th)	Borderline-High (50th–80th)	High (80th–95th)	Very High (≥95th)
LDL-P (LDL Particle Number)		906	< 1000	1000-1299	1300-1599	1600-2000	> 2000

Lipids

	mg/dL	Optimal	Near or above optimal	Borderline-High	High	Very High
LDL-C (calculated)	80	< 100	100-129	130-159	160-189	≥190

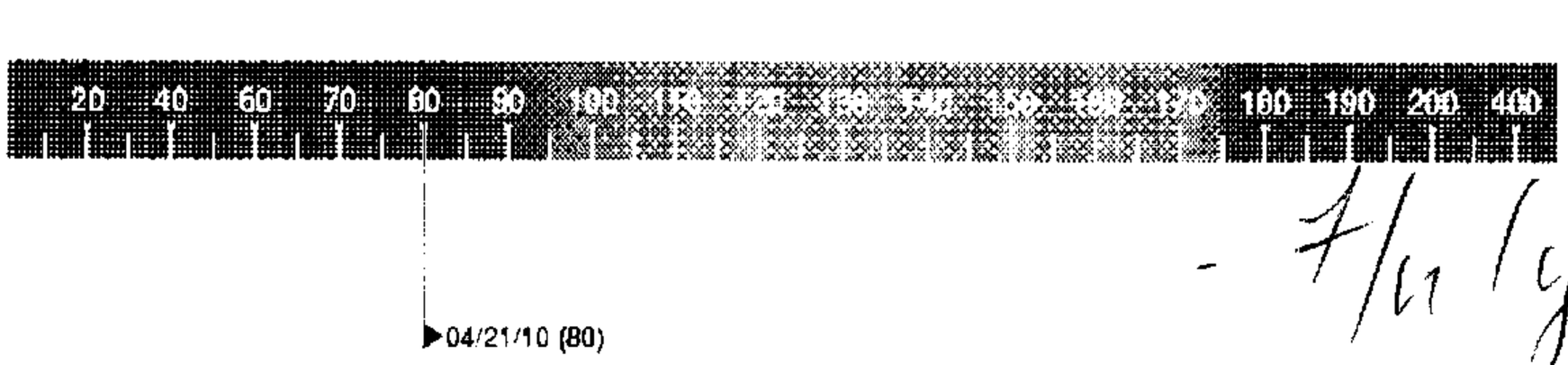
	mg/dL		mg/dL		mg/dL
HDL-C	40	**Triglycerides**	68	**Total Cholesterol**	134
	Desirable ≥ 40		Desirable < 150		Desirable < 200

Historical Reporting

LDL-P

- optimal LDL-P

LDL-C



- f/u 1 year

1. Reference population comprises 5,382 men and women not on lipid medication enrolled in the Multi-Ethnic Study of Atherosclerosis (MESA). Mora, et al. *Atherosclerosis* 2007.

91-001-00R1.0

4/28/10

CLIA: 34D0952253

LIPOSCIENCE

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Patient Name	Sex	Age
ABITBUL, YOSSI	M	33

Patient ID	Birth Date	Accession Number
16154201	10/03/1976	H0556379

Clinician: RICHMAN, MICHAEL

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Center for Cholesterol Mgmt 15057/
1950 Sawtelle Blvd
Suite 150
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Date Collected	Date Received	Report Date and Time	Requisition Number	Fasting Status
04/21/2010	04/22/2010	04/23/2010 06:32	16154201	FASTING

PARTICLE CONCENTRATION AND SIZE

LDL and HDL Particles

Lower CVD Risk ← → Higher CVD Risk

Percentile in Reference Population[3]

		µmol/L
HDL-P (total)	31.9	high 75th 50th 25th low

		nmol/L
SMALL LDL-P	484	low 25th 50th 75th high

		nm
LDL SIZE	20.7	Large (Pattern A) 29.0 – 20.6; Small (Pattern B) 20.5 – 19.0

Small LDL-P and LDL Size are associated with CVD risk, but not after LDL-P is taken into account.

Lipoprotein Markers Associated with Insulin Resistance and Diabetes Risk[1,2]

Insulin Sensitive ← → Insulin Resistant

Percentile in Reference Population[3]

		nmol/L
LARGE VLDL-P	1.3	low 25th 50th 75th high

		nmol/L
SMALL LDL-P	484	low 25th 50th 75th high

		µmol/L
LARGE HDL-P	3.3	high 75th 50th 25th low

		nm
VLDL SIZE	41.9	small 25th 50th 75th large

		nm
LDL SIZE	20.7	large 75th 50th 25th small

		nm
HDL SIZE	8.6	large 75th 50th 25th small

Insulin Resistance Score

		0-100
LP-IR SCORE**	49	insulin sensitive 25th 50th 75th insulin resistant

** The LP-IR Score combines the information from the above 8 markers to give improved assessment of insulin resistance and diabetes risk.

These laboratory assays, validated by LipoScience, have not been cleared by the US Food and Drug Administration. The clinical utility of these laboratory values has not been fully established.

1. Garvey WT, et al. *Diabetes* 2003; 532:453-462. 2. Gott DC et al. *Metabolism* 2006; 54:264-270. 3. LipoScience reference population comprises 4,588 men and women without known CVD or diabetes and not on lipid medication.

CLIENT 7016 | PATIENT

MICHAEL RICHMAN, M.D.
ACCT #7016
1950 SAWTELLE #150
LOS ANGELES, CA
90025
(310)481-3939

LAST NAME | FIRST NAME
ADDRESS
CITY | STATE | ZIP CODE
SEX M F | BIRTH DATE | PHONE

WESTERN HEALTH SCIENCES
MEDICAL LABORATORY

21018 Osborne St.
Canoga Park, CA 91304
818-773-9771

☐ **STAT**

REFERRING PHYSICIAN

DATE SUBMITTED MO DAY YR

BILL TYPE
☐ DR.
☐ PATIENT
☒ INSURANCE
☐ MEDICARE
☐ MED-CAL
☐ MED-MED

PATEINT SOCIAL SECURITY NUMBER

INSURANCE COMPANY /ADDRESS CITY/STATE/ZIP CODE

SUBSCRIBER NO | GROUP NO

PLEASE ATTACH COPY OF INSURANCE, MEDICARE, OR MEI-CAL CARD Attached

DATE TIME OF COLLECTION ☐A.M. ☐P.M.

MEDICARE REQUIRES THAT ONLY THOSE PROCEDURES THAT ARE MEDICALLY NECESSARY FOR DIAGNOSIS AND TREATMENT AND NOT FOR SCREENING PURPOSE SHOULD BE ORDERED WHEN MEDICARE REIMBURSEMENT IS SOUGHT

DIAGNOSIS

LAB USE	GRN	UR
SST	GRY	CUL
RED	BLU	STL
LAV	YEL	CSF

ACCESSION	LABEL

PHLEB 300 ____ (INITIAL)
COLL 900 ____ (INITIAL)

☐ PHONE RESULTS TO ☐ FAX RESULTS TO

		HEMATOLOGY		ICD-9 CODE
124	X	CBC w/platelets & diff	(L)	
125		HEMOGRAM	(L)	
127		WESTERGREN SED RATE	(L)	
542		PROTIME	(B)	
143		APTT	(B)	
PROFILES		(See Over for Components)		
1205		BASIC METABOLIC	(S)	
1200	X	COMPREHENSIVE METABOLIC	(S)	
204		ELECTROLYTES	(S)	
1118		LIPID	(S)	
206		HEPATIC FUNCTION	(S)	
2209		PRENATAL	(R.S.L.)	
1206		RENAL FUNCTION	(S)	
861		HEPATITIS ACUTE SCREEN	(S)	
		HEPATITIS		
707		HEP A ANTIBODY TOTAL	(S)	
756		HEP A ANTIBODY IgM	(S)	
627		HEP B SURFACE ANTIGEN	(S)	
622		HEP B SURFACE ANTIBODY	(S)	
711		HEP B CORE ANTIBODY IgM	(S)	
677		HEP C ANTIBODY	(S)	
		MICROBIOLOGY		
SOURCE				
		CULTURE ROUTINE		
803		CULTURE URINE		
151		GRAM STAIN		
805		BETA STREP SCREEN		
723		CULTURE, HERPES		
		CHLAMYDIA, PCR		
		G.C., PCR		
157		OVA AND PARASITES		
156		OCCULT BLOOD		

		INDIVIDUAL TESTS		ICD-9 CODE
701		AFP, TUMOR	(S)	
621		AMMONIA (FRZ PLASMA)	(L)	
128		AMYLASE	(S)	
192		ANA	(S)	
654		CA 15-3	(S)	
268		CA 19-9	(S)	
164		CA 125	(S)	
500		CARBAMAZEPINE (TEGRETOL)	(S)	
171		CEA	(S)	
111		CHOLESTEROL (TOTAL)	(S)	
175		CHOLESTEROL, HDL	(S)	
220		CHOLESTEROL, LDL DIRECT	(S)	
373		CMV,IgG,IgM	(S)	
135		CPK (TOTAL)	(S)	
498		CRP-QNT	(S)	
515		DHEA SULFATE	(R)	
501		DIGOXIN	(R)	
502		DILANTIN(PHENYTOIN)	(R)	
359		EBV IgG,IgM,NA,EA	(S)	
420		ESTRADIOL	(S)	
194		FERRITIN	(S)	
512		FOLATE (FOLIC ACID)	(S)	
517		FSH	(S)	
110		GLUCOSE	(G)	
630		GLYCOHEMOGLOBIN (A1C)	(L)	
292		HSV I & II, IgG	(S)	
289		HSV I & II, IgM	(S)	
540		HIV (EIA)	(S)	
952		HOMOCYSTEINE	(S)	
460		IMMUNOGLOBULINS(IgG,IgA,IgM)	(S)	
516		LUTEINIZING HORMONE	(S)	
503		LITHIUM	(S)	

		INDIVIDUAL TESTS		ICD-9 CODE
140		MAGNESIUM	(S)	
141		MONO TEST	(S)	
374		NT-pro BNP	(S)	
504		PHENOBARBITAL	(S)	
118		POTASSIUM	(S)	
153		PREGNANCY,SERUM (QNT)	(S)	
274		PREGNENOLONE	(S)	
519		PROGESTERONE	(S)	
520		PROLACTIN	(S)	
28		PROSTATE SPECIFIC ANTIGEN	(S)	
428		PSA (FREE + TOTAL)	(S)	
379		PTH W/CALCIUM	(S)	
145		RA (LATEX)	(S)	
146		RPR	(S)	
100		SGOT/AST	(S)	
112		SGPT/ALT	(S)	
287		SHBG	(S)	
196		T3 UPTAKE	(S)	
325		T3 FREE	(S)	
333		T3 (TOTAL)	(S)	
122		T4 (THYROXINE)	(S)	
240		T4 FREE	(S)	
368		THYROGLOBULIN Ab	(S)	
706		THYROID PEROXIDASE Ab	(S)	
514		TESTOSTERONE (TOTAL)	(S)	
523		TESTOSTERONE (FREE + TOTAL)	(S)	
116		TRIGLYCERIDES	(S)	
121		TSH	(S)	
154		URINALYSIS W/MICRO	(U)	
8330		URINE MICROALBUMIN	(U)	
511		VITAMIN B-12	(S)	
766		VITAMIN D, 25-OH	(S)	

OTHER TESTS, REMARKS

LIPOSCIENCE

2500 Sumner Blvd. • Raleigh, NC 27616
(919) 7[illegible]1999 • FAX (919) 212-1954
CLIA #34D0952253

1615420

FACILITY

Center for Cholesterol Mgmt 15057
1950 Sawtelle Blvd
Suite 150
Los Angeles, CA 90025
(310)481-3939 Fax: 13104813949

Designate Requesting Clinician

☒ 1972554806 RICHMAN, MICHAEL F

Additional Clinician: NPI:

[illegible] [illegible]
Collection Date (mm/dd/yy) Collection Time

ICD-9 Code(s) : REQUIRED

[illegible]

PATIENT INFORMATION

All information must be completed for sample to be processed

Social Security Number

Patient ID/Medical Record Number

Abichal, Yossi
Last Name First Name Middle

[illegible]
Address

[illegible]
City State Zip

[illegible]
Date of Birth (mm/dd/yy)

☒ Male ☒ Fasting

☐ Female ☐ Non-Fasting

Telephone

INSURANCE : REQUIRED

Attach copy of insurance card (front and back)

☐ Medicare ☒ Insurance ☐ Client ☐ Patient

Medicare No. (including suffix)

BCBS ID No. (including prefix)

Insurance Company Name

Insured Name Employer Name/Employer #

Member/Insured ID# Group #

Claims Address

[illegible]
City State Zip

Patient Relation to Insured: ☒ Self ☐ Spouse ☐ Dependent

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.

[illegible]
Patient/Responsible Party Signature Date

[illegible] 6060 620 110\125\140\150\179\245\410

PANELS (See back for list of tests included in each panel)

600 ☐	***NMR LipoProfile® test*** (LDL-P only) Chemical Lipids+Particle Concentration & Size	P/S
610 ☐	***NMR LipoProfile® test*** (LDL-P only) Chemical Lipids+Particle Concentration & Size +Homocysteine+CRP	P/S
620 ☐	***NMR LipoProfile® test*** (LDL-P, HDL-C, TG by NMR) TC+Particle Concentration & Size	P/S
630 ☐	***NMR LipoProfile® test*** (LDL-P only) LDL-P+Particle Concentration & Size	P/S
699 ☐	Lipid Panel, Chemical Method (CPT 80061)	P/S

INDIVIDUAL TESTS

140	☐	ALT (CPT 84460)	P/S	
150	☐	AST (CPT 84450)	P/S	
170	☐	C-Peptide (CPT 84681)	S	
180	☐	Cholesterol, Total (CPT 82465)	P/S	
245	☐	Creatine Kinase (CK), Total (CPT 82550)	P/S	
125	☐	CRP-High Sensitivity (CPT 86141)	P/S	
178	☐	Glucose (CPT 82947)	OX	
179	☐	Glycohemoglobin (A1c) (CPT 83036)	L	
190	☐	HDL Cholesterol (CPT 83718)	P/S	
110	☐	Homocysteine (CPT 83090)	P/S	
160	☐	Insulin (CPT 83525)		
195	☐	LDL Cholesterol, Direct (CPT 83721)	P/S	
308	☐	LDL-P Only (CPT 83704)	P/S	
100	☐	Lp(a) (CPT 83695)	P/S	
545	☐	*NMR LipoProfile®* test (LDL-P, HDL-C, TG by NMR) (CPT 83704)	P/S	
602*	☐	Particle Concentration & Size (CPT 83704)	P/S	
410	☐	TSH (CPT 84443)		
420	☐	T-4, Free (CPT 84439)		
430	☐	T-4, Total (CPT 84436)		
185	☐	Triglycerides (CPT 84478)	P/S	

* These laboratory-developed assays have not been cleared by the US Food and Drug Administration. Whether requested individually (602) or as part of a test panel (see back for list of tests included in each panel), the results of these assays will be provided in a laboratory report separate from that provided for other tests.

OPTIONAL

☐ White/Caucasian ☐ Hispanic
☐ Black/African American ☐ Asian
☐ Other: _____ ☐ Decline

1615420 1615420

tion, Storage, and Shipping Instructions on Back

ATTACH ABN IF NECESSARY

White Copy - LipoScience
Yellow Copy - Client

81-520-01R1.

HBI CENTER FOR HOUSEHOLD MANAGEMENT
A Medical Corporation
9150 Sawtelle Blvd. Suite 150
Los Angeles, CA 90025

Please complete all pages of this form

NAME: Yossi Abitbol DATE: 4-21-2010

SEX: ✓M ___F DOB: 10 03 1976 SSN: DL#: D2228457

ADDRESS: 12916 moorpark st # 106

CITY: Studio City STATE: CA ZIP: 91604

FAX: EMAIL: PHONE: 310-418-8348

EMERGENCY CONTACT: Orly Tal PHONE 323-353-4555

ADDRESS: 5330 Natick Ave

CITY: Sherman Oaks STATE: CA ZIP: 91411

EMPLOYER: Self 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:

N/A

Have you ever been diagnosed with?

High Blood Pressure ___ Yes X No How long ago? _____

Diabetes ___ Yes X No How long ago? _____

Stroke ___ Yes X No When did it occur? _____

High Cholesterol ___ Yes X No What medications do you take for this, if any? N/A

Lung Disease ___ Yes X 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.

N/A

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

N/A

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	MJ mom	
Heart Attack	MJ dad and Brother	
Angina or clogged arteries		
Sudden death		
Hypertension		
Other heart disease		

High cholesterol N/A

Stroke N/A

Diabetes N/A

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? N/A
- ☐ Any tests done for your heart? What tests? N/A

When where they done? _____

After any problems you wish to address at this visit?

Yossi Mitelman

Patient name (sign)

4-21-2010

Date

4-21-2010

Witness

Date

INSURANCE INFORMATION

Please provide us with your medical insurance information.

PRIMARY INSURANCE POLICY:

Company: Aetna Phone: 1800 962-6842

Policy #: W700 50178 Group: 884166-020-00001

Name and SS# of Insured Yossi Abitbul

SECONDARY INSURANCE POLICY:

Company: N/A Phone:

Policy #:

Name and SS# of Insured:

OTHER INSURANCE:

Company: N/A 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, C A 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 AN VALID AS THE ORIGINAL.

Your signature here

4-21-2015
Today's 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, the Center for Cholesterol Management may decline to provide treatment to me.

Signature of patient or legal guardian:

Date:

Patient's Name:

Witness:

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: 4-21-2010

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: 4-21-2010

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: 4-21-2015

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NAP

J.H. COHN LLP

CHOICE POS II
REFERRALS NOT REQUIRED

ID W17[redacted] 50178 GRP:884166-020-00001 BIN# 610502 RX

01 SHL[redacted]T TAYARI-ABITBUL — PCP: NO ELECTION REQUIRED
02 SHA[redacted]ABITBUL — PCP: NO ELECTION REQUIRED
03 YOS[redacted] ABITBUL — PCP: NO ELECTION REQUIRED

MEMBER SERVICES	1-800-962-6842	PCP	$ 30.00
PROVIDERS CALL	1-888-632-3862	SPC	$ 30.00
		NO	$ 200.00
		ER	$ 50.00
	PAYOR NUMBER 60054 0110	UC	$ 30.00

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[redacted] health/substance abuse coverage: precertification or questions call 1-800-424-4047.
REFERRALS ARE NOT REQUIRED.
For services that require precertification, call the number on the front of this card. In an emergency, call the local hotline (ex. 911) or go to the nearest emergency facility. Notify Member Services promptly after treatment. While coverage is in force, members are entitled to plan benefits, subject to exclusions and limitations. For eligibility/benefit information, call Member Services. Participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna. Plan underwritten or administered by Aetna Life Insurance Co. This card does not guarantee coverage.

We recommend you use a Primary Doctor to coordinate your care.

AETNA
PO BOX 981106
EL PASO TX 79998-1106

AT0152

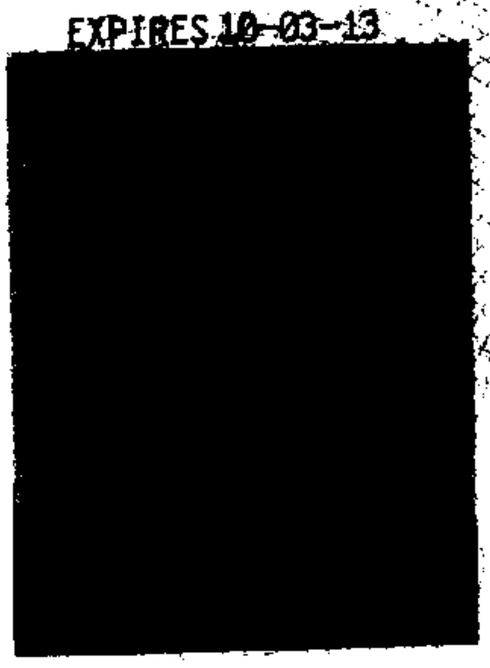
CALIFORNIA

DRIVER LICENSE

CLASS: C

EXPIRES 10-03-13

D2228457



YOSSI ABITBUL
12916 MOORPARK ST 106
STUDIO CITY CA 91604

SEX:M HAIR:BLK
HT:5-10 WT:150

DOB:10-03-76

08/13/2008 239 RB FD/13