MAZIAR GHODSIAN, D.O., P.C.

□ 300 South Beverly Drive, Suite 105
Beverly Hills, CA 90212

□ 19582 Beach Blvd, Suite 270
Huntington Beach, CA 92648

Please answer the following questions:

1. Have you or anyone in your household ever tested positive for COVID-19?If so, when?

YES _____ NO _____

Date: _____

2. Have you had contact with anyone who tested positive for COVID-19 in the past 21 days?

YES _____ NO _____

3. Have you or anyone in your household had any of the following symptoms in the last 21 days:

- sore throat, cough, chills, body aches for unknown reasons,
- shortness of breath for unknown reasons
- loss of smell, loss of taste
- fever greater than 100 degrees Fahrenheit

YES _____ NO _____

4. Have you received the vaccine for COVID-19? If so, when ?

YES (1 dose) _____ YES (2 doses) _____ NO _____

Vaccine Brand: _____

Date: _____

MAZIAR GHODSIAN, D.O., P.C.

PATIENT REGISTRATION FORM

□ 300 South Beverly Drive, Suite 105
Beverly Hills, CA 90212

□ 19582 Beach Blvd, Suite 270
Huntington Beach, CA 92648

(800)280-6384

NAME_____DOB___/___/___ AGE ____REFERING DOCTOR_____ DATE___/___/___

SEX: □MALE □FEMALE **GENDER**: □MALE □FEMALE □TRANSGENDER **RACE**: □CAUCASIAN □HISPANIC □AFRICAN AMERICAN □ASIAN □OTHER

RELIGION: _____ MARITAL STATUS □SINGLE □MARRIED □DIVORCED □SEPARATED □PARTNER □OTHER

STREET ADDRESS_____CITY_____STATE____ZIP_____

HOME PHONE (____)_____CELL PHONE (____)_____WORK PHONE (____)_____

EMAIL ADDRESS_____

EMPLOYER NAME_____OCCUPATION_____

STREET ADDRESS_____CITY_____STATE____ZIP_____

SPOUSES NAME_____ SPOUSES EMPLOYER NAME_____

STREET ADDRESS:_____CITY_____STATE____ZIP_____

SPOUSES OCCUPATION:_____CELL PHONE (____)_____WORK PHONE (____)_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____ RELATIONSHIP TO PATIENT _____

PATIENT'S SOCIAL SECURITY NUMBER_____ SPOUSE'S SOCIAL SECURITY NUMBER_____

EMERGNECY CONTACT NAME & TELEPHONE NUMBER_____ RELATIONSHIP _____

PREFERRED PHARMACY:_____ PHONE (____)_____FAX (____)_____

STREET ADDRESS:_____CITY_____STATE____ZIP_____

I HEREBY AUTHORIZE DR. MAZIAR GHODSIAN, D.O. TO RELEASE ANY AND ALL MEDICAL INFORMATION NECESSARY TO HELP PROCESS MY CLAIM AND REQUESTS TO ALL MY INSURANCE CARRIERS AND/OR OTHER THIRD-PARTY PAYORS, AS MAY BE REQUIRED OR REQUESTED FOR THE PROCESSING OF CLAIMS FOR INSURANCE. I HEREBY AUTHORIZE THAT THE PAYMENT OF ALL BENEFITS BE MADE TO DR. MAZIAR GHODSIAN

I UNDERSTAND AND AGREE THAT I AM SOLELY RESPONSIBLE FOR PAYMENTS OF MY ACCOUNT AND THAT PAYMENT IS DUE REGARDLESS OF INSURANCE COVERAGE. I FURTHER UNDERSTAND AND AGREE THAT ANY AND ALL BALANCES REMAINING AFTER INSURANCE APPROVES OR DENIES PAYMENT WILL BE MY RESPONSIBILITY TO PAY IN WHOLE.

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION I PROVIDED IS CORRECT TO THE BEST OF MY ABILITY AND AUTHORIZE THE PAYMENT OF ANY INSURANCE OR OTHER MEDICAL BENEFITS DIRECTLY TO DR. MAZIAR GHODSIAN.

LA PEER SURGICAL CENTER, LLC: WE WISH TO INFORM YOU THAT MAZIAR GHODSIAN, D.O. HAS A FINANCIAL OWNERSHIP INTEREST IN THE LA PEER SURGERY CENTER HEALTH CARE FACILITY. YOU HAVE THE RIGHT TO USE ANY ALTERNATIVE FACILITY OF YOUR CHOICE. YOU ARE NOT OBLIGATED TO USE ANY FACILITY RECOMMENDED BY DR. MAZIAR GHODSIAN AND HE WILL BE HAPPY TO PROIVDE YOU WITH ALTERNATIVE FACILITIES THAT PROVIDE SIMILAR SERVICES OR PROCEDURES.

BY SIGNING BELOW, I CERTIFY THAT I ACKNOWLEGE AND I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS.

PATIENT NAME_____PATIENT SIGNATURE _____ DATE _____

GUARANTOR NAME (IF OTHER THAN PATIENT)_____GUARANTOR SIGNATURE _____DATE_____

MAZIAR GHODSIAN, D.O., P.C.

PATIENT FINANCIAL RESPONSIBILITY & ASSIGNEMENT OF BENEFITS ARGREEMENT

□ 300 South Beverly Drive, Suite 105
Beverly Hills, CA 90212

□ 19582 Beach Blvd, Suite 270
Huntington Beach, CA 92648

(800)280-6384

NAME_____DOB___/___/___ DATE___/___/___

THANK YOU FOR CHOOSING OUR OFFICE TO ASSIST YOU WITH YOUR MEDICAL NEEDS. IN THE INTEREST OF GOOD HEALTHCARE PRACTICES, WE FEEL IT IS IMPORTANT TO SET FORTH OUR MUTUAL UNDERSTANDING IN THIS PATIENT FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS AGREEMENT ("AGREEMENT") WITH YOU TO AVOID ANY PAYMENT DISPUTES. OUR PRIMARY GOAL IS TO HELP OUR PATIENTS EXPERIENCE GREAT HEALTH AND WE WISH TO SPEND OUR TIME AND ENERGY TOWARDS THAT END.

WE ARE NOT CONTRACTED WITH ANY INSURANCE COMPANIES. AS A COURTESY TO YOU, OUR OFFICE CAN PROVIDE YOU WITH THE SUPERBILL CONTAINING THE SERVICES PROVIDED WHICH YOU MAY PRESENT TO YOUR INSURANCE COMPANY AND MAY RECEIVE REIMBURSEMENT IF YOUR PLAN PROVIDES FOR IT. ANY REIMBURSEMENT THAT MAY OR MAY NOT PROVIDED TO YOU BY YOUR INSURANCE COMPANY IS YOUR SOLE RESPONSIBILITY. YOU ARE RESPONSIBLE BY ANY AND/OR ALL OUTSIDE CARE PROVIDED BY ALL OUTSIDE SERVICES INCLUDING BUT NOT LIMITED TO PATHOLOGY, ANESTHESIOLOGY, SURGERY CENTER(S), AND HOSPITAL(S).

PLEASE INITIAL ALL SECTIONS BELOW TO DEMONSTRATE YOUR UNDERSTANDING OF EACH PROVISION.

PLEASE INITIAL

_____ **METHODS OF PAYMENT ACCEPTED:** CASH, CREDIT CARDS, AND CARE CREDIT ARE THE ONLY ACCEPTABLE METHODS OF PAYMENT. PAYMENT SHALL BE MADE AT THE TIME THE SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

_____ **WE ARE NOT CONTRACTED WITH ANY INSURANCE COMPANIES. FOR INDIVIDUAL/GROUP INSURANCE, OUR OFFICE IS AN OUT OF NETWORK PROVIDER.** YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. **THEREFORE, YOU ARE ULTIMATELY**

RESPONSIBLE FOR PAYMENT OF ALL CHARGES. IT IS YOUR RESPONSIBILITY TO RESOLVE DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING ANY REIMBURSEMENT(S). WE REQUIRE THAT YOUR ACCOUNT BE PAID IN FULL WITHIN 30 DAYS OF THE DATE OF SERVICE IF SPECIAL ACCOMODATIONS ARE MADE. IF YOU NEED AN EXTENDED PAYMENT PLAN, PLEASE CONTACT OUR **OFFICE AT (800) 280- 6384.**

_____ **MEDI-CAL & MEDICARE:** WE ARE NOT A PARTICIPATING PROVIDER AND WE DO NOT ACCEPT MEDI-CAL OR MEDICARE. THEREFORE, YOU WILL BE RESPONSIBLE FOR ALL CHARGES AT THE TIME SERVICES ARE RENDERED. IF YOU HAVE MEDICARE, IT IS YOUR RESPONSIBILITY TO NOTIFY THIS OFFICE AND COMPLETE THE MEDICARE BENEFICIARY AGREEMENT. THEREFORE, YOU WILL SOLEY BE RESPONSIBLE FOR ALL CHARGES AT THE TIME SERVICES ARE RENDERED.

_____ **FINANCIAL ASSISTANCE:** WE WILL BE PLEASED TO ASSIST YOU WITH ANY QUESTIONS REGARDING AVAILABLE PAYMENT OPTIONS. WE ARE COMMITTED TO PROVIDING SERVICE TO THOSE WHO MAY NEED FINANCIAL ASSISTANCE. IF YOU HAVE QUESTIONS REGARDING FINANCIAL ASSISTANCE, PLEASE CONTACT OUR **OFFICE AT (800) 280- 6384**.

_____ **RETURNED CHECK POLICY**

THERE IS A $50.00 SERVICE CHARGE ON ALL RETURNED CHECKS. *AFTER RECEIVING A RETURNED CHECK, OUR OFFICE WILL ONLY ACCEPT CASH.*

_____ **CANCELLATION/NO SHOW POLICY**

WHILE UNDERSTANDING THERE MAY BE TIMES WHEN YOU MISS AN APPOINTMENT DUE TO EMERGENCIES OROBLIGATIONS, OUR OFFICE REQUIRES AT LEAST 24 HOURS NOTICE ON ALL CANCELLED APPOINTMENTS. OUR OFFICE CHARGES A FEE OF $100.00 FOR APPOINTMENTS AND $300 FOR ANY PROCEDURES OR SURGERIES NOT CANCELLED OR RESCHEDULED WITHIN 72 HOURS IN ADVANCE. CANCELLATION/NO SHOW FEES MUST BE PAID PRIOR TO YOUR NEXT APPOINTMENT.

_____ **FORM COMPLETION POLICY**

THERE IS A FEE OF $35.00 FOR ALL COMPLETED FORMS AND IS DUE UPON PICK UP.

COLLECTIONS

_____

IF YOU FAIL TO MEET THE FINANCIAL OBLIGATIONS AGREED UPON IN THIS AGREEMENT OR FAIL TO MAKE OTHER PAYMENT ARRANGEMENTS WITH THIS OFFICE, YOUR OUTSTANDING BALANCE WILL BE SENT TO A COLLECTION AGENCY AND THE COMPLETE BALANCE WILL HAVE TO BE PAID IMMEDIATELY. IF YOU FAIL TO COMPLY WITHIN 7 DAYS OF RECEIPT AND COLLECTION ACTIVITY IS INSTITUTED, WHETHER BY A COLLECTION AGENCY OR AN ATTORNEY OR BOTH, YOU AGREE TO BE RESPONSIBLE FOR AND PAY IN ADDITION TO THE CHARGES FOR SERVICES AND TREATMENT RECEIVED, ALL COSTS REASONABLY ASSOCIATED WITH SUCH COLLECTION ACTIVITY INCLUDING, BUT NOT LIMITED TO, REASONABLE COLLECTION FEES, ATTORNEYS FEES, SKIP TRACING COSTS, AND COURT COSTS.

ASSIGNMENT OF BENEFITS

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTOOD AND AGREE TO ABIDE BY THIS AGREEMENT. I ALSO AGREE TO THE FOREGOING INFORMATION REGARDING MY RESPONSIBILITY FOR THE SERVICES PROVIDED.

PATIENT NAME PRINTED: _____ DOB:_____

PATIENT SIGNATURE _____ DATE:_____

RESPONSIBLE PARTY _____ DATE:_____

Maziar Ghodsian,D.O., P.C.

CONSENT TO TREATMENT

□ 300 South Beverly Drive, Suite 105
Beverly Hills, CA 90212

□ 19582 Beach Blvd, Suite 270
Huntington Beach, CA 92648

(800)280-6384

NAME_____DOB___/___/___ AGE ____REFERING DOCTOR_____ DATE___/___/___

THANK YOU FOR CHOOSING MAZIAR GHODSIAN D.O., P.C. FOR YOUR MEDICAL CARE. OUR OFFICE IS COMMITTED TO PROVIDING YOU WITH QUALITY MEDICAL AND SURGICAL CARE. WE ASK THAT YOU READ, SIGN AND RETURN THIS FORM TO US PRIOR TO YOUR TREATMENT.

BY SIGNING THIS CONSENT TO TREATMENT,YOU, THE PATIENT ("PATIENT" COLLECTIVELY INCLUDES THE INDIVIDUAL RECEIVING TREATMENT AS THE SIGNATORY BELOW, THE PARENT OF A MINOR CHILD, OR THE LEGALLY AUTHORIZED REPRESENTATIVE OF THE INDIVIDUAL RECEIVING TREATMENT FOR WHOM THE SIGNATORY BELOW IS LEGALLY RESPONSIBLE OR DULY AUTHORIZED TO ACT ON BEHALF OF) AUTHORIZE MAZIAR GHODSIAN D.O., P.C. AND/OR ITS STAFF ("STAFF") TO PROVIDE MEDICAL AND SURGICAL CARE. "STAFF" INCLUDES BUT IS NOT LIMITED TO, EMPLOYEES AND/OR INDEPENDENT CONTRACTORS WHO NOW OR IN THE FUTURE TREAT THE PATIENT WHILE EMPLOYED BY, WORK WITH OR ARE ASSOCIATED WITH OR SERVE AS BACK-UP FOR MAZIAR GHODSIAN D.O., P.C.. FURTHERMORE, "STAFF" ALSO INCLUDES INDIVIDUALS WORKING AT MAZIAR GHODSIAN D.O., P.C. OR ANY OTHER OFFICE OF MAZIAR GHODSIAN D.O., P.C., WHETHER SIGNATORIES TO THIS FORM OR NOT, WHO MAY PERFORM AND/OR ORDER MEDICAL AND SURGICAL TREATMENTS, EXAMS, TESTS, AND/OR PROCEDURES. ADDITIONALLY, "STAFF" MAY ADMINISTER AND PRESCRIBE MEDICATION, AND ANY OTHER CARE DEEMED NECESSARY OR ADVISABLE FOR THE DIAGNOSIS AND TREATMENT OF THE PATIENT'S MEDICAL CONDITION OR TO PROVIDE MEDICAL AND SURGICAL TREATMENT, EXAMS, AND PERFORM ANY SUCH PROCEDURES OR OTHER CARE AS DEEMED NECESSARY OR ADVISABLE FOR THE DIAGNOSIS AND TREATMENT OF YOUR MEDICAL CONDITION. THIS CONSENT IS VALID FOR EACH VISIT TO MAZIAR GHODSIAN D.O., P.C. UNLESS REVOKED BY THE PATIENT IN WRITING.

THE PATIENT SHALL NOT EXPECT MAZIAR GHODSIAN D.O., P.C. OR ITS STAFF TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL POSSIBLE RISKS AND COMPLICATIONS OF TREATMENT. HOWEVER, INFORMED CONSENT WILL BE OBTAINED BY THE STAFF OF MAZIAR GHODSIAN D.O., P.C. BEFORE ANY PROCEDURE IS PERFORMED. THE PATIENT HEREBY AGREES THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND FURTHER AGREES THAT NO ONE HAS GIVEN HIM/HER ANY PROMISES, GUARANTEES, OR WARRANTIES ABOUT THE RESULT OF ANY CARE OR TREATMENT HE/SHE RECEIVES OR EXAMINATIONS HE/SHE UNDERGOES AT MAZIAR GHODSIAN D.O., P.C.. THE PATIENT HEREBY UNDERSTANDS AND AGREES THAT RESULTS ARE NOT GUARANTEED.

THE PATIENT HEREBY UNDERSTANDS AND AGREES THAT ALL LABORATORY, PATHOLOGY AND RADIOLOGICAL TESTS AND ANESTHESIA ORDERED BY THE EVALUATING PRACTITIONER AT MAZIAR GHODSIAN D.O., P.C. WILL BE THE SOLE FINANCIAL RESPONSIBILITY OF THE PATIENT TO BE PAID IN FULL. PATIENTS WILL ONLY CONTACTED BY OUR OFFICE OF ABNORMAL RESULTS BY THE AFOREMENTIONED TESTS.

THE PATIENT HEREBY AUTHORIZES MAZIAR GHODSIAN D.O., P.C. TO RELEASE ANY AND ALL INFORMATION RELATED TO ANY TREATMENT RECEIVED AT THIS CLINIC TO THE PATIENT'S PRIMARY CARE PHYSICIAN OR SPECIALIST PHYSICIANS UPON THEIR REQUEST.

BY VOLUNTARILY SIGNING BELOW, I, THE PATIENT, HEREBY CONSENT TO, HAVE READ, OR HAVE HAD READ TO ME, AND UNDERSTAND THE TERMS SET FORTH ABOVE AND HAVE HAD AN OPPORTUNITY TO ASK ANY AND ALL QUESTIONS REGARDING THIS CONSENT TO TREATMENT. I UNDERSTAND AND INTEND THIS CONSENT TO TREATMENT TO BE VALID FOR AND COVER THE ENTIRE COURSE OF TREATMENT FOR ALL SERVICES FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT AT MAZIAR GHODSIAN D.O., P.C. FROM THE DATE SIGNED FORWARD.

_____

DATE

_____ _____

PATIENT'S PRINTED NAME PATIENT'S SIGNATURE

_____ _____

PRINTED NAME OF PATIENT'S REPRESENTATIVE SIGNATURE OF PATIENT'S REPRESENTATIVE

AND RELATIONSHIP TO PATIENT

Maziar Ghodsian D.O.,P.C.

HIPAA AUTHORIZATION FORM

□ 300 South Beverly Drive, Suite 105
Beverly Hills, CA 90212

□ 19582 Beach Blvd, Suite 270
Huntington Beach, CA 92648

(800)280-6384

NAME_____DOB___/___/___ AGE ____REFERING DOCTOR_____ DATE___/___/___

FEDERAL LAW, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996, PUB. L. 104-191 AND 45 CFR Part 160 AND SUBPARTS A AND E OF PART 164 REQUIRES US TO OBTAIN CONSENT FROM YOU IN ORDER TO COMMUNICATE WITH YOU REGARDING YOUR HEALTH INFORMATION. PLEASE PLACE A CHECK MARK NEXT TO THE FORM OF COMMUNICATION THAT YOU AUTHORIZE OUR OFFICE TO EMPLOY IN CONTACTING YOU WITH YOUR HEALTH INFORMATION, INCLUDING BUT NOT LIMITED TO TEST RESULTS, MEDICAL RECORDS, APPOINTMENT REMINDERS, OFFICE FORMS.

- □ I HEREBY AUTHORIZE MAZIAR GHODSIAN DO PC TO CONTACT ME BY TELEPHONE AND LEAVE A VOICE MESSAGE AT NUMBERS WHICH I HAVE PROVIDED (□ALL □HOME, □WORK, □MOBILE ETC)
- □ I HEREBY AUTHORIZE MAZIAR GHODSIAN DO PC TO CONTACT ME BY NON ENCRYPTED EMAIL
- □ I HEREBY AUTHORIZE MAZIAR GHODSIAN DO PC TO CONTACT ME BY NON ENCRYPTED TEXT
- □ I HEREBY AUTHORIZE MAZIAR GHODSIAN DO PC TO CONTACT ME BY NON ENCRYPTED FACSIMILLE
- □ I HEREBY AUTHORIZE MAZIAR GHODSIAN DO PC TO CONTACT ANY OF MY PHYSICIANS AND DISCUSS MY MEDICAL RECORDS BY PHONE AND/OR NON ENCRYPTED FACSIMILLE AND/OR NON ENCRYPTED EMAILAND/OR NON ENCRYPTED TEXT
- □ I HEREBY AUTHORIZE MAZIAR GHODSIAN DO PC TO CONTACT MY SPOUSE AND DISCUSS MY MEDICAL RECORDS AND/OR BILLING RECORDS BY PHONE AND/OR NON ENCRYPTED FACSIMILLE AND/OR NON ENCRYPTED EMAILAND/OR NON ENCRYPTED TEXT
- □ **I HEREBY AUTHORIZE MAZIAR GHODSIAN DO PC TO UTILIZE ALL OF THE ABOVE METHODS TO COMMUNICATE WITH ME, MY SPOUSE AND PHYSICIANS REGARDING MY HEALTH INFORMATION PROTECTED UNDER HIPAA.**

I HEREBY AUTHORIZE THE MAZIAR GHODSIAN DO PC TO COMMUNIATE WITH ME USING THE METHODS CHECKED OFF ABOVE REGARDING MY HEALTH INFORMATION PROTECTED UNDER HIPAA. I UNDERSTAND AND HEREBY ACKNOWELGE THAT EMAIL, TEXT AND FACSIMILLE COMMUNICATIONS ARE NOT ENCRYPTED AND MAY NOT BE PRIVATE BUT AUTHORIZE THE MAZIAR GHODSIAN DO PC TO COMMUNICATE WITH ME USING THESE MODALITIES.

PATIENT NAME_____PATIENT SIGNATURE_____ DATE_____

Maziar Ghodsian,D.O.,P.C.

ACKNOWLEDGMENT OF PATIENT FINANCIAL RESPONSIBILITY

□ 300 South Beverly Drive, Suite 105
Beverly Hills, CA 90212

□ 19582 Beach Blvd, Suite 270
Huntington Beach, CA 92648

(800)280-6384

NAME_____DOB___/___/___ DATE___/___/___

PLEASE READ CAREFULLY:

WE ARE NOT CONTRACTED WITH ANY INSURANCE COMPANIES. IT IS YOUR RESPONSIBILITY TO RESOLVE DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING ANY REIMBURSEMENT(S). AS A COURTESY TO YOU, OUR OFFICE CAN PROVIDE YOU WITH THE SUPERBILL CONTAINING THE SERVICES PROVIDED WHICH YOU MAY PRESENT TO YOUR INSURANCE COMPANY AND MAY RECEIVE REIMBURSEMENT IF YOUR PLAN PROVIDES FOR IT. ANY REIMBURSEMENT THAT MAY OR MAY NOT PROVIDED TO YOU BY YOUR INSURANCE COMPANY IS YOUR SOLE RESPONSIBILITY. **YOU ARE RESPONSIBLE FOR ANY AND/OR ALL OUTSIDE CARE PROVIDED BY ALL OUTSIDE SERVICES INCLUDING BUT NOT LIMITED TO PATHOLOGY, ANESTHESIOLOGY, SURGERY CENTER(S), AND HOSPITAL(S).**

PATIENT NAME PRINTED: _____ DOB:_____

PATIENT SIGNATURE _____ DATE:_____

RESPONSIBLE PARTY _____ DATE:_____

Maziar Ghodsian ,D.O.,P.C.

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PHOTO CONSENT

Dr. Ghodsian is an active researcher in the field of Proctologic Surgery and therefore may publish the results of his procedures in scientific journals and on the Internet for informational purposes. Most importantly, we use photographs to track our patients' progress. We will de-identify all photographs before publication. In order to publish your photographs, it is necessary to have your consent below.

CONSENT

I hereby irrevocably consent to and authorize the use of any reproduction by Maziar Ghodsian, DO, PC, and his affiliates, or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken that Maziar Ghodsian, DO, PC, and/or his affiliates has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about proctologic surgery and proctologic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Image via print, video and other electronic media, specifically including any affiliated websites of Maziar Ghodsian, DO, PC, website and social media sites. The images (including any photographic negatives) shall be the sole property of Maziar Ghodsian, DO, PC.

I hereby waive any right to inspect or approve the finished product, photograph, video, or matter that may be used or to the eventual use that it might be applied. I hereby release, discharge and agree to hold harmless, Maziar Ghodsian, DO, PC, and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission of authority, from and against any and all claims whatsoever in connection with the use of my Images and the reproduction thereof as stated above, including any claims for payment in connection with the distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned. I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

PATIENT SIGNATURE_____ PATIENT NAME_____
DATE_____

I am the parent, guardian, or conservatory of _____, a minor.

PATIENT REPRESENTATIVE NAME_____DATE_____

PATIENT REPRESENTATIVE SIGNATURE_____

MAZIAR GHODSIAN, D.O., P.C.

COMPREHENSIVE REVIEW OF SYSTEMS

☐ 300 South Beverly Drive, Suite 105
Beverly Hills, CA 90212

☐ 19582 Beach Blvd, Suite 270
Huntington Beach, CA 92648

(800)280-6384

NAME_____DOB___/___/___ REFERING DOCTOR_____ DATE___/___/___

GENERAL HEALTH

☐FEVER
☐RECENT WEIGHT CHANGES
☐CHANGE IN APPETITE
☐SLEEP PROBLEMS

EYES

☐CHANGE IN VISION
☐GLASSES OR CONTACT LENSES
☐BLURRED OR DOUBLE VISION

EAR, NOSE, THROAT

☐HEARING LOSS OR RINGING
☐EARACHES
☐CHRONIC SINUSITIS
☐MOUTH SORES
☐SORE THROAT
☐BALANCE PROBLEMS

CARDIOVASCULAR

☐CHEST PAIN
☐PALPATATIONS
☐EDEMA
☐HIGH BLOOD PRESSURE

RESPIRATORY

☐SHORTNESS OF BREATH
☐CHRONIC COUGH
☐ASTHMA

GASTROINTESTINAL

☐LOSS OF APPETITE
☐DIFFICULTY SWALLOWING
☐NAUSEA/VOMITING
☐HEARTBURN
☐ABDOMINAL PAIN
☐BLOATING

RECTUM

☐RECTAL BLEEDING
☐RECTAL PAIN
☐RECTAL ITCHING
☐RECTAL BURNING
☐RECTAL LEAKAGE
☐RECTAL MASS
☐DIARRHEA
☐CONSTIPATION
☐CHANGE IN BOWEL HABBITS
☐PAINFUL BOWEL MOVEMENTS
☐FECAL INCONTINENCE
☐BLOOD IN STOOL
☐INCONTINENCE TO FLATUS
☐INCREASE IN FLATUS
☐SWELLING
☐MASS OR LUMP
☐RASH
☐MUCUS PER RECTUM
☐HEMORRHOIDS
☐THROMBOSED HEMORRHOIDS
☐PROTRUSION OF RECTAL TISSUE
☐WARTS
☐REDNESS
☐FOREIGN BODY

GENITOURINARY/KIDNEY

☐VAGINAL BLEEDING/IRREGULAR MENSES
☐VAGINAL PAIN
☐BURNING OR PAINFUL URINATION
☐BLOOD IN URINE
☐KIDNEY STONES

MUSCULOSKELETAL

☐JOINT PAIN
☐BACK PAIN

SKIN

☐RASH OR ITCHING
☐HAIR LOSS
☐JAUNDICE
☐WOUNDS/SORES

NEUROLOGICAL

☐FREQUENT HEADACHES
☐NUMBNESS OR TINGLING
☐MEMORY LOSS

ENDOCRINE

☐EXCESSIVE THIRST OR URINATION
☐HEAT OR COLD INTOLERANCE

HEMATOLOGIC/LYMPHATIC

☐BLEEDING OR BRUISING TENDANCY
☐ANEMIA

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGE IN MY MEDICAL STATUS.

PATIENT NAME_____ PATIENT SIGNATURE_____DATE_____

I AFFIRM THAT I HAVE REVIEWED THE INFORMATION ABOVE AND DISCUSSED IT WITH THE PATIENT IN DETAIL.

☐ **MAZIAR GHODSIAN, D.O. SIGNATURE_____DATE_____**