COR MEDICAL GROUP

Jeffrey F. Caren, MD, FACC
Mark K. Urman, MD, FACC, FASE, FAHA
Diplomates American Board of Internal Medicine in Cardiovascular Diseases

310.659.0715
Cedars-Sinai Medical Office Towers
8635 West Third Street, Suite 890W
Los Angeles, California 90048

Welcome to our office

Dr. Caren and Dr. Urman are board-certified specialists in Cardiology. If you are here for a consultation, your own family doctor or internist probably has referred you to us. When we have finished our examination we will return you to your doctor and send him or her a complete report with our recommendations for treatment. When acting as consultant we usually see the more difficult or complex cases; those in which your doctor wants an independent specialist's opinion. Our evaluation is based on a complete review of available medical records and x-rays, history, physical examination and any new tests and/or procedures that may be necessary to arrive at that opinion. Often, your physician will want us to periodically reassess your condition.

Most of our services and tests will generally be covered by your insurance to the *extent that your specific plan specifies* (and according to your *out-of-network benefits* if you are not covered by Medicare). If you still have questions, please feel free to discuss our fees with our office manager, Ms. Lilly Garzona or our billing specialists before the consultation or initial visit. Our fee schedule is based on the time we spend (both with you as well as any review of records and test results) and the complexity of the case. If special procedures or laboratory tests are necessary, extra fees will be charged for those services (and your insurance billed on your behalf). Our billing specialists will be happy to assist you with questions regarding fees, insurance or billing matters.

With your permission, we will send a copy of your medical record to any doctor you may wish to see.

Please try to make calls to us during the hours of 8:45 am to 5 pm Monday through Friday. Please be advised that we cannot treat a patient for an extended period by telephone. When we are not in the office our telephone voice mail will respond to you call. Please listen carefully to the instructions given.

We make no charge for brief, routine phone calls or filling prescriptions during office hours. <u>We ask that these calls not be made at night or on weekends</u>. Pharmacies or discount medication programs *must electronically send or fax us their requests*. Proper medical care means that certain prescriptions cannot be indefinitely refilled without reevaluation in person here in our office at whatever time-period your condition dictates.

If, at any time, you would like a formal second opinion regarding your condition, please do not hesitate to ask. We will offer you the names of competent cardiologists in your area and furnish them with our records.

We encourage you, during office visits, to ask for a full explanation of your medical problems. Do not leave with unanswered questions. You should ask for all that we can answer concerning your condition.

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The following patient registration information sheet and health history questionnaire are being sent to you prior to your appointment so that you may take the necessary time to fully complete these forms. One of the most important parts of the medical record your doctor keeps about you is a health history concerning your past and present health problems, and any personal information, which might affect the state of your health. Your answers will be treated confidentially as will all parts of your upcoming visit.

Please return this questionnaire to your doctor or his medical assistant when you come for your appointment. Take all the time you need to complete this questionnaire. Answer each question as best you can be filling in the information asked for or by putting an "☒" or "☑" in the appropriate space. Choose the answer to each question which in your mind comes closest to applying to you.

If there is any question you have difficulty answering, do not worry and just circle the question. You can discuss it with the doctor when you return the questionnaire. Be sure to bring it with you so that you and the doctor can go over your answers during your appointment within a confidential setting. The questionnaire is not intended to be a substitute for your doctor spending time with you. Completing the forms as fully as you possibly can, will allow the doctor to spend *more* time with you on subjects that both you and he feel are most important. In addition, it will allow the doctor to spend *more* time with you getting to know you personally.

DO NOT FORGET:

- Bring your ***insurance card*** and any other third-party payor information with you to our office.
- Bring the completed ***patient registration*** information sheet and health history questionnaire with you to our office at the time of your appointment.
- Bring any old or ***prior medical records*** that you can or arrange to have them sent to us prior to your appointment. This is especially ***important*** if you are seeing the doctor in consultation or in second opinion

COR Medical Group

Patient Registration Information Form

(Note: **PLEASE PRINT clearly and legibly!** or type form)

Last name: _____ First: _____ Middle: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Home phone*: (____)_____ **Cell***: (____)_____ **Work***: (____)_____ extension_____

Preferred contact: ☐ Home ☐ Cell ☐ Work **e-mail address**: _____@_____

***Can a voice mail message be left?** ☐ Yes ☐ No If yes, **on which phone(s)**: ☐ **Home** ☐ **Cell** ☐ **Work**

Date of birth: _____/_____/_____ (MONTH / DAY / YEAR) Social Security Number: _____ - _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Dom partner ☐ Widow(er) ☐ Divorced ☐ Separated **Sex:** ☐ Male ☐ Female

Emergency Contact (not spouse) Name: _____ Relationship: _____

Emergency Phone Number: (____)_____ Spouse's name **and** number: _____

Patient's Employer: _____ Occupation: _____

Employer's address: _____

Referred by: _____ **Primary Doctor:** _____

Insured / subscriber's name (if different from patient): _____ Insured's DOB:____/___ /_____

Insurance Information

[PLACE COPY OF CARD(S) HERE]

AUTHORIZATION TO PAY PHYSICIAN

I hereby assign all medical benefits, to include major medical benefits to which I am entitled (i.e., I authorize my insurance provider to pay directly to the physician responsible for my care), to: COR Medical Group, Inc. (including Jeffrey F. Caren, M.D., and/or Mark K. Urman, M.D.). I understand that if Mark K. Urman, M.D. or Jeffrey F. Caren, M.D. are not contracted providers of my medical insurance company, COR Medical Group, Inc. will bill my insurance company for out-of-network benefits (where applicable) as a courtesy. This assignment will remain in effect until revoked by me in writing. A photocopy of this original assignment is to be considered as valid as an original. I understand that I am fully responsible for any amount or balance due after insurance payment is made for this claim (or any non-covered services made known to me prior to treatment) by the insurance company. I specifically understand that even if I have insurance coverage, I am responsible for payment of services. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required. I hereby authorize the doctor/medical group to release to the above named insurance carrier or company, any and all necessary information and/or records relating to services rendered to me during the period of treatment.

Signature of patient: _____ Date: _____

Signature of Guardian/Witness: _____ Date: _____

COR Medical Group Health History Questionnaire

Please print your name:_____ Date of appointment: _____

Reason for visit: _____

List *all* medications you are now taking (including non-prescription or "over-the-counter" medications, vitamins and/or herbs). List doses and frequency taken. If unsure of any information, bring your medications in their prescription bottles with you to the office for review.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Are you allergic to any medications or other substances?: (If so, please list the adverse reaction(s) that you have had to each drug)

_____

Please list all times you have been hospitalized, operated on, or seriously injured:

Year	Operation, illness, or injury	Hospital and City
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Immediate Family's Health History ("blood relatives") – **PLEASE BE COMPLETE**:

	Age (if living)	Age at death	state of health (and medical conditions) OR cause of death
Mother…….…	_____	_____	_____
Father……..	_____	_____	_____
Siblings……	_____B/S	_____	_____
	_____B/S	_____	_____
	_____B/S	_____	_____
	_____B/S	_____	_____
	_____B/S	_____	_____
	_____B/S	_____	_____
Children……	_____	_____	_____
	_____	_____	_____

Please circle "B" for brother or "S" for sister

Other Medical Care

If you are being treated for any other illnesses or medical problems by another physician or physical or mental health practitioner, please describe the problems and write the name of the physician, health practitioner or medical facility treating you.

Illness or Medical Problem	Physician or Medical Facility	Address and/or Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Patient Comments:

_____

_____

_____

_____

_____

Patient's Signature:_____ Date:_____

COR Medical Group Health History Questionnaire – Part II – **Review of Systems**

Please print your name:_____ Date of appointment with doctor: _____

Note: Answer each question as best you can and provide more detailed information as necessary in the space at the bottom of the page.

Do you have, or have you recently (within the last 6 months*) had:

* Unless specifically asked if you ***ever*** have had…

		Yes	No
1.	Unexplained recurrent and/or persistent ☐fever, ☐chills, ☐perspiration or ☐night sweats?		
2.	Significant weight loss? (or significant weight gain: ☐ or significantly decreased or increased appetite?)		
3.	Unexplained persistent fatigue, lethargy, malaise or unusual tiredness? (or general weakness☐)		
4.	Unusual persistent or recurrent ☐itching, ☐skin rash, ☐eczema or ☐psoriasis?		
5.	Any new or unusual moles, birthmarks that have changed or non-healing sores?		
6.	Frequent or unusual headaches?		
7.	☐Hearing loss, ☐ringing in the ears (tinnitus), ☐ear pain or ☐discharge from an ear?		
8.	Frequent nose bleeds?		
9.	Any history of unusual head congestion, sinus infections, tenderness or pain?		
10.	A ☐harsh or shrill sound from the throat with breathing or ☐persistent sore throat?		
11.	Hayfever, rhinitis, allergies or persistent runny nose or nasal discharge or stuffiness?		
12.	☐A change in voice or hoarseness? ☐Pain in your jaw when eating or talking?		
13.	Gum disease or bleeding, dental disease or mouth sores?		
14.	Full or partial dentures?		
15.	Any change in vision, ☐blurred vision, ☐double vision, ☐glaucoma or ☐cataracts?		
16.	Any ☐eye pain when looking at light, ☐general eye pain, ☐eye discharge or ☐eye redness?		
17.	Any history of high blood pressure or hypertension?		
18.	High cholesterol?		
19.	Chest, arm, shoulder, neck, upper back, or jaw pain related to exertion *or* mental stress?		
20.	Persistent chest pains of any sort?		
21.	Frequent, recurrent or persistent palpitations or skipped heart beats?		
22.	Shortness of breath when lying flat or the need for extra pillows at night to help you breathe easier?		
23.	Pain or cramping in your calves or legs that is reproducible with walking?		
24.	Swelling of the ankles, feet or body?		
25.	Episodes of shortness of breath awakening you in the middle of the night or requiring you to sit up?		
26.	Do you smoke? If yes, for how many years?_____ How much per day?_____ If not now, have you ***ever*** smoked?_____ and how much and for how long?_____		
27.	Have you been told you snore excessively or loudly?		
28.	Persistent, recurrent or frequent cough?		
29.	☐Coughing up of blood? ☐Sputum production?		
30.	Shortness of breath or difficulty breathing (☐with or ☐without exertion)?		
31.	Wheezing, asthma, *chronic* bronchitis, or emphysema?		
32.	Recurrent of frequent lightheadedness?		
33.	Episodes of fainting (passing out) with or without loss of consciousness?		
34.	Have you ***ever*** been resuscitated or been told that your heart stopped?		
35.	Did you ***ever*** have rheumatic fever, an infection of your heart valves, or use intravenous drugs?		
36.	Have you ***ever*** been told that you have a heart murmur or that you *always* need to take antibiotics if you have a dental procedure or cleaning?		
37.	Easy bruising or bleeding?		
38.	Environmental allergies or potentially dangerous environmental exposure?		
39.	Unusual persistent thirst or need to drink large amounts of fluids or water?		
40.	History of anemia, cancer or tumor or have you ***ever*** received a blood transfusion?		

Please use this space to further explain any answers to the above questions:_____

_____

_____

_____

(please continue on the **next page**)

Please print your name:_____ Date of appointment with doctor: _____

		Yes	No
41.	Pain in your stomach or abdomen associated with eating or "heartburn"		
42.	Recurrent or persistent ☐nausea or ☐vomiting?		
43.	Vomiting of blood or what looks like coffee grounds?		
44.	Persistent or recurrent abdominal pain or any disease of the intestines or colon (such as: ulcers, diverticulosis or diverticulitis, colitis, or Crohn's disease)?		
45.	Recurrent or persistent diarrhea, loose or watery stools?		
46.	Increased frequency of bowel movements or change in bowel habits?		
47.	Constipation or painful bowel movements?		
48.	Blood in the stool; rectal bleeding, pain, itching or hemorrhoids?		
49.	Black or black and tarry stools?		
50.	Have you ***ever*** had yellow eyes or skin or jaundice?		
51.	Have you ***ever*** had gallstones, liver disease or hepatitis		
52.	Difficulty or pain when you swallow?		
53.	A hernia?		
54.	Pain or burning when urinating?		
55.	☐Urinary urgency or ☐increased urinary frequency?		
56.	☐Blood in the urine or ☐cloudy appearing urine?		
57.	Flank tenderness or pain or history of kidney stones?		
58.	Urinary dribbling or difficulty initiating urination?		
59.	Kidney or bladder disease?		
60.	Penile or vaginal discharge or genital sores or history of genital herpes or venereal disease?		
61.	Impotence or sexual dysfunction?		
62.	MEN ONLY: Any history of prostate problems? (skip #63, then **continue with question # 64**)		
63.	WOMEN ONLY: a) Approximate date of last menstrual period:_____ b) Typical menstrual cycle length _____ Days of flow_____ c) Vaginal bleeding between menses (periods)?_____ d) Total number of pregnancies_____ live births_____ miscarriages_____ abortions _____ e) Date of last PAP smear_____ Last mammogram _____		
64.	Persistent or recurrent muscle aches, pain, or weakness?		
65.	Recurrent or persistent ☐neck pain or stiffness and/or ☐back pain or stiffness?		
66.	Joint pain or swelling, or history of arthritis, gout or rheumatic diseases?		
67.	Recurrent falls or falls with significant injury?		
68.	Persistent or recurrent swollen glands or lumps in your neck, armpits or groin?		
69.	Unusual heat or cold intolerance or history of thyroid problem?		
70.	Vertigo, dizziness, or loss of balance?		
71.	☐Pain or ☐tingling of one part of your body? ☐Change in speech?		
72.	☐Focal weakness or ☐numbness of one side or part of your body, or a history of a ☐stroke?		
73.	☐Tremor, uncontrollable shaking or ☐seizures?		
74.	☐Loss of consciousness or ☐head injury?		
75.	Depression or suicidal ideas?		
76.	Substance abuse or hallucinations?		
77.	Nervousness or anxiety?		
78.	Difficulty falling asleep or inability to sleep soundly?		
79.	Memory loss, forgetfulness or unusual irritability?		
80.	Have you ***ever*** had: Polio, mumps, measles, German measles (Rubella)?		
81.	Do you exercise regularly?		
82.	How much alcohol do you drink and how often?		

Please use this space to further explain any answers to the above questions:_____
_____
_____
_____

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Caren or Urman will review your health history and conduct an initial evaluation to determine whether it is appropriate for you to be a regular patient with our practice.

COR Medical Group, Inc.

JEFFREY F. CAREN, M.D., F.A.C.C. **MARK K. URMAN, M.D., F.A.C.C.**

DIPLOMATES AMERICAN BOARD OF INTERNAL MEDICINE AND CARDIOVASCULAR DISEASES

Cedars-Sinai Medical Towers
8635 West Third Street, Suite 890W
Los Angeles, California 90048

To Our Patients:

This notice describes how health information about you as a patient in our practice may be used and disclosed, and how you can get access to your records. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPPA).
The law requires COR Medical Group, Inc. to provide you with the following important information:

I. Disclosure of Your Health Information in Special Circumstances:

1. We must disclose records for lawsuits and similar proceedings in response to court or administrative order.

2. We must disclose records if required to do so by a law enforcement official

3. We must disclose records if required by the appropriate authorities if you are a member of the military including veterans.

4. We must disclose records to federal officials for intelligence and national security activities as authorized by law.

5. We must disclose records to correctional institutions or law enforcement officials if you are under the custody of law enforcement officials.

6. We must disclose records for workers compensation and similar programs.

II. Your Right Regarding Your Health Information:

1. Communications - You can request that COR Medical Group, Inc. communicate with you about your health and related issues in a particular manner or a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your records to only certain individuals involved in your care of the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to threat you.

You have the right to inspect and obtain a copy of your records that may be used to make decisions about you, including billing records. You must submit your request in writing to:

Dr. Jeffrey Caren or Dr. Mark Urman
8635 West Third Street
Suite 890 West
Los Angeles, CA 90048

You may fax your request to (310) 659-0664, or you may verbally request copies of your records while in the office. COR Medical Group has 30 days to respond to your request for copies.

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to either doctor. In your written request you must provide the doctors with a reason that supports your request for amendment. COR Medical Group, Inc. has 60 days to respond.

Health Information Notice

1. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy, which we will have on hand at our front desk.

2. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact either Dr. Jeffrey Caren or Mark Urman. All complaints must be submitted in writing you will not be penalized for filing a complaint.

3. You have the right to provide an authorization for other uses and disclosures. COR Medical Group, Inc. will obtain your written authorization for uses that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of COR Medical Group's Notice of Privacy Practices.

Name: _____ Date: _____
Please print

Name: _____ Date: _____
Signature

PATIENT RECORD OF DISCLOSURES - HIPAA

The "Health Insurance Portability and Accountability Act" *(HIPAA)* gives individuals the right to request a restriction on uses and disclosures of "Personal Health Information" *(PHI)*. The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as correspondence to the individual's office instead of home.
The Privacy Rule generally requires Healthcare providers to take steps to limit their use or disclosure of your PHI. Healthcare entities must keep records of PHI disclosures.
Note: Use and disclosure for emergencies may be permitted without prior consent.
I wish to be contacted in the following manner: *(please check all that apply)*

☐ **Home Phone:** _____

☐ **Cell Phone:** _____

☐ **Work Phone:** _____

☐ **Fax Number:** _____

☐ **Other Phone:** _____

☐ **Okay to leave basic messages with callback number only.**
☐ **Okay to leave detailed messages with specific information.**

Written & Electronic Communications:

☐ **Okay to mail information to my home address.** *(See Patient Information Form for Address)*
☐ **Okay to mail information to my work/office address.** *(See Patient Information Form for Address)*

☐ **E-Mail:** _____ *(may not be secure)*

The following individuals may have access to my "Personal Health Information" *(PHI)*:

NAME	RELATIONSHIP	PHONE NUMBER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing my name below, I acknowledge that I received a copy of this office "NOTICE OF PRIVACY PRACTICES" outlining how my confidential "Personal Health Information" *(PHI)* will be used, disclosed and protected.

† _____ _____

PATIENT SIGNATURE **DATE**

Save Form Print Form

COR Medical Group, Inc.

Authorization for release of medical information

PATIENT INFORMATION (please **print** clearly):

Patient Name: _____ Date of Birth: _____

Telephone #: _____ Social Sec #: _____

I, hereby authorize (prior doctor)_____, located at:

Address:_____

City, State, Zip: _____

Phone Number:_____

Fax Number: _____

To disclose and release copies of my medical records* to (circle one):

Mark K. Urman, M.D. **Jeffrey F. Caren, M.D.**

COR Medical Group, Inc.
8635 West Third Street #890W
Los Angeles, CA 90048
310-659-0714 fax 310-659-0664

*Please include all pertinent cardiac testing and/or evaluation reports (including but not limited to: echocardiograms, EKG's, stress tests, angiograms, cholesterol panels, cardiac consultations, history & physicals, etc).

Duration: I understand that this authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.

Revocation: I understand that this authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party of others have acted in reliance upon this authorization.

I understand that a photocopy or facsimile of this authorization will be considered as valid as the original.

I will be fully responsible for any delay caused by failure to complete this form accurately and entirely.

I understand that a copy of the requested records will be sent to the destination I have specified.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF RECORDS FOR THE PURPOSE STATED ABOVE.

Signed _____ Date _____
(Patient or Authorized Representative of Patient)

COR Medical Group, Inc.
A Professional Corporation
Jeffrey F. Caren, M.D., F.A.C.C. Mark K. Urman, M.D., F.A.C.C., F.A.S.E.
DIPLOMATES AMERICAN BOARD OF INTERNAL MEDICINE - SUBSPECIALTY OF CARDIOVASCULAR DISEASES

8635 West Third Street, Suite 890-W • Los Angeles, California 90048
(310) 659-0714 • Fax: (310) 659-0664
www.CORMedicalGroup.com

OFFICE FINANCIAL POLICY

Thank you for choosing our office and cardiologists. We are committed to personalized care to help achieve the best heart health possible for you. We hope you understand that payment of your bill is considered part of your evaluation and treatment. The following is a statement of our financial policy which we require you read, agree to, and sign, prior to any evaluation or treatment. This financial policy applies to all services rendered by or supervised by our doctors in our office or during any hospitalization involving our doctors' care.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services or charges, any deductible amount not previously met and any co-pay amount due, at the time services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are NOT contracted with will be required to pay for the first visit in full at the time services have been rendered. For any follow-up visits you will need to pay for the doctor's evaluation and management services in full. For some testing, a minimum of 50% initial payment will be required at the time services are rendered but any balance remaining after we have billed your insurance company will be your responsibility and due immediately after we notify you. Please speak to our billing staff to make specific arrangements.

If you are insured with a plan that we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your co-pay amount, at the time of each visit.

Patients with no insurance coverage are expected to pay for services at the time services are rendered.

Please note: Effective September 1, 2014, a $20.00 late fee will be applied to all outstanding balances 31 days past due and interest charges will be assessed at 1.25% monthly (15% annually). Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in sending your bill to a collection agency. This likely will affect your credit score.

Our accepted methods of payment are cash, Visa, MasterCard, American Express or check. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

As a courtesy, we try to research your specific insurance policy's coverage and estimate what will and won't be covered as best as possible. However, it is the patient's responsibility to verify their benefits for their particular plan and to make sure all the proper authorizations have been obtained. Likewise, we cannot guarantee that medical insurance companies will pay exactly as we have estimated in advance. Some insurance plans reduce benefits when the insured patient is being treated by doctors outside of the designated network or the proper authorizations have not been obtained.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibilities or payment options, please contact our insurance / billing department.

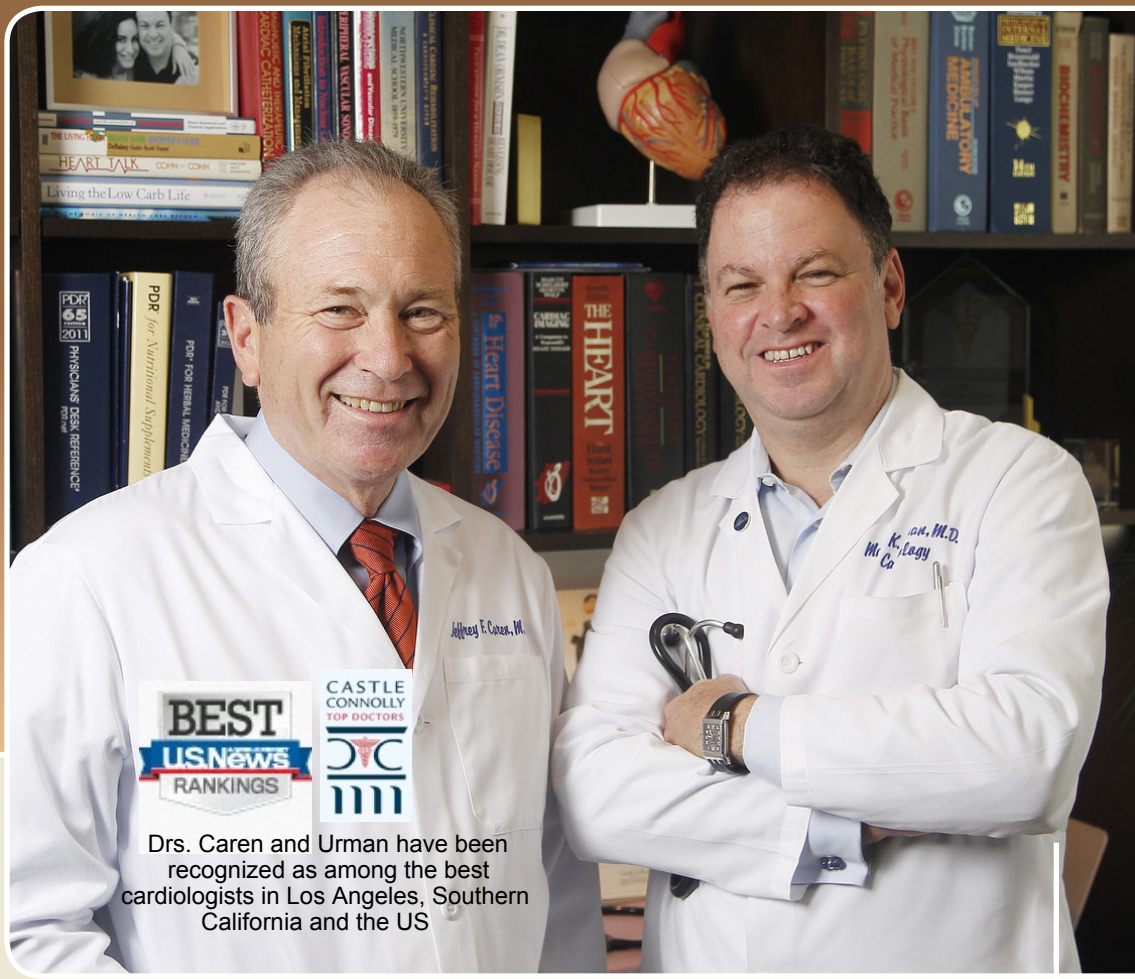
"I have read, understand and agree to the provisions of this policy."

/ /

Patient Signature Date

Jeffrey F. Caren, MD, FACC
Mark K. Urman, MD, FACC, FASE, FAHA

Diplomates American Board of Internal Medicine
in Cardiovascular Diseases



Drs. Caren and Urman have been recognized as among the best cardiologists in Los Angeles, Southern California and the US

A MEDICAL PRACTICE DEDICATED TO THE PREVENTION, DIAGNOSIS AND TREATMENT OF HEART DISEASE.

Enhanced Access Membership Program

- Personalized concierge services not covered by private insurance or Medicare
- Increasing levels of priority and enhanced access for routine appointments and testing
- Increased phone and email access to our staff and doctors on routine matters
- Priority completion of administrative paper-work (with fees waived)
- Validated parking and convenient VIP parking for office visits

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Please contact our office for more information.

Cedars-Sinai Medical Office Towers
8635 West 3rd Street, Suite 890W
Los Angeles, California 90048
Phone : 310.659.0715

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CORMedicalGroup.com

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Prescription Refill Policy

To Our Patients:

We want to help you with your prescription refills. In our office, we have numerous calls, electronic requests and faxes throughout the day from pharmacies for our patients' prescription needs.

So that we are able to get medications you need in a timely fashion, here are some things you can do to work with us.

1. ***Watch your medication dates*** – ask for your refills two to four business days before they run out (or several weeks if sending away for your prescriptions).

   Plan ahead! Last minute requests can cause problems for you.

2. ***Please call your pharmacy directly*** to ask for refills. We can only accept **electronic or** fax requests from pharmacies to ensure accuracy of your prescriptions. We need to hear from them as we cannot routinely call them.

3. ***Ask pharmacies to electronically send*** or fax ***us your request***. We will return your approvals within **two (2) business days**. Thus, please anticipate when your medications will run out and plan accordingly.

4. ***Please try not to go to the pharmacy and wait for them to call us*** for a refill approval without two business days' advance notice. If your doctor is not available, you may not get immediate service on routine refill requests.

PLEASE NOTE: We strongly recommend that you ask your pharmacy to electronically send us prescription requests immediately after you inform them of the need and then confirm with the pharmacy that your prescription is ready. We cannot be responsible for pharmacies that themselves wait until the last minute to send us requests. Electronically filed requests from pharmacies that go directly to the patient's electronic medical chart in our office provide for the quickest turn-around time.

COR Medical Group
Jeffrey F. Caren, M.D., F.A.C.C. **Mark K. Urman, M.D., F.A.C.C.**
DIPLOMATES AMERICAN BOARD OF INTERNAL MEDICINE AND SUBSPECIALTY OF CARDIOVASCULAR DISEASES

Effective January 1, 2003

Appointment Cancellation Policy

How many times have you attempted to schedule an appointment with your doctor (or a test in the office), only to find out that his schedule is full?

Increasingly, many patients are unable to keep scheduled appointments without calling us or canceling. This problem decreases our ability to see patients like you, when you need to see your doctor urgently.

If you need to reschedule or cancel an appointment, we certainly will understand, but please kindly **notify us at least 24 hours in advance** to avoid an administrative fee.

This policy applies to all appointments to see your doctor or for an in-office test.

Remember that a no show/no call appointment takes an opportunity away from those who need to see their doctor or have a test done urgently. And maybe next time, that will be you.

Thank you in advance for your cooperation.

Jeffrey F. Caren, MD, FACC
Mark K. Urman, MD, FACC, FASE
Diplomates American Board of Internal Medicine & Cardiovascular Diseases

COR MEDICAL GROUP

Cedars-Sinai Medical Office Towers
8635 West Third Street, Suite 890W
Los Angeles, California 90048
310.659.0715

Location, Directions, Maps and Parking

The offices of Drs. Jeffrey Caren and Mark Urman are located in 8635 West Third Street (the West Office Tower of The Cedars-Sinai Medical Office Towers) in Los Angeles adjacent to Cedars-Sinai Medical Center and near the Beverly Center and Beverly Hills. The main office is in Suite 890W and patients are also sometimes seen, tested or evaluated in Suite 355W.

Parking is available off of George Burns Road and (as of July 2012) costs $2.25 per 15 minutes with a maximum of $18.00. Please read posted signs for up-to-date cost. We do not validate.

COR Medical Group, Inc.
(The offices of Dr. Jeffrey Caren and Dr. Mark Urman)
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Tel: (310) 659-0714

You may also park 2 – 3 blocks away at the Beverly Center (as of July 2009 - please check the latest rates), self-parking rates are: $1.00 per hour for the first 4 hours, $2.00 each additional hour and $ 10.00 maximum.

Parking is also available on surrounding city streets, most of which is meter parking. We advise that you carefully read posted signs. However, we do not recommend street meter parking for your first visit. As the doctors do want to make sure they can thoroughly review your history and spend time with you, depending on the complexity of your medical history and case, be prepared to spend at least two hours in our office during your first visit.

As we all know, traffic can be challenging in Southern California. Please allow adequate driving time depending on traffic conditions to be able to arrive in plenty of time including finding parking. After all, if you are in a big rush to your appointment, your blood pressure might be higher when the doctor sees you!

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