GABOR VARI, M.D.

11980 SAN VICENTE BOULEVARD, SUITE 810

LOS ANGELES, CA 90049

310-820-3200

FAX310-882-6528

www.varimd.com

Welcome to the office!

Your first appointment with Dr. Vari will last up to 90 minutes. When you arrive in the waiting room please flip the switch under Dr. Vari's name so that the indicator light is on. This will tell the doctor that you have arrived. Please also bring current medications you are taking with you in their prescription bottles. Also bring contact information for physicians, therapists, or other important people the doctor may want to correspond with regarding you.

Please fill out the entire intake packet and bring it with you to the appointment. Please fill out the credit card authorization form at the end of the packet even if you prefer to pay with other means. The office requires a valid credit card number on file.

If you wish to give Dr. Vari permission to speak with a third party regarding your care, please be sure to sign a release of information form. This form is available for download on the website. Often times it is helpful for Dr. Vari to collaborate in your treatment with your therapist, primary care physician, or another family member. This is something you can discuss in more detail with Dr. Vari.

Please remember to cancel or change all appointments at least 48 hours in advance. Missed sessions or sessions changed with less than 48 hours notice will result in a full charge.

The office is located at 11980 San Vicente Blvd, Suite 810, in Brentwood. It is in a large high rise building along San Vicente on the south side of the street between Montana and Bundy. There is valet parking available in the building, the parking entrance is a raised ramp off of San Vicente about 500 feet east of Bundy. It is easy to miss so go slowly and stay in the right lane. Valet parking is $2 for 15 minutes. The office does not validate parking. Alternatively, meter parking may be available along San Vicente. Street parking may be available on surrounding streets such as Montana and Bundy.

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Directions:

From the 405
Exit Wilshire Blvd. West
Continue on Wilshire until Bundy (about 1.3 miles), the intersection has a Ralph's and the Literati Café on the Northeast corner
Turn right (North) onto Bundy and proceed on Bundy as it winds around until San Vicente Blvd (about 0.7 miles)
Turn right onto San Vicente Blvd and the building driveway is about 500 feet on the right hand side

From the 10 Freeway
Take the 405 north and follow directions above.

Dr. Vari looks forward to meeting you.

GABOR VARI, M.D.

11980 San Vicente Blvd., Suite 810
Los Angeles, CA 90049

Phone: (310) 820-3200
Fax: (310) 882 - 6528

Consent for Evaluation and/or Treatment

Please take a moment to review these office policies and procedures before receiving psychiatric services.

Any information you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or unless law or professional standards of practice require its release. In particular, your right to confidentiality may not be maintained if you are in immediate danger to yourself or someone else, and steps must be taken to assure your own or another's safety. Also, any clinician hearing about domestic violence from a patient or anyone that a child or elder is being or has been physically or psychologically abused is required by law to report this information to a designated agency. If it is necessary to disclose some information you have provided to anyone else, this will be discussed with you.

Office Policy

Insurance: We are not providers for any insurance companies; therefore it is your responsibility to seek reimbursement of payments made to us. You are responsible for payment of your medical care, regardless of the status of your claim. You will be provided with an itemized statement to submit to your insurance carrier at the end of each month.

Financial: All visits must be paid for at the time of the visit. Please provide credit card information to be charged or kept on file for charges incurred and not paid for by check at the time of your visit, and/or to be used for charges for missed appointments or late payments. There is a returned check fee of $25.00.

In the event that you have an outstanding balance after the 20th day of the following month in which service was rendered, your account will be subjected to a late fee charge of $20.00. This fee will be charged each month for any outstanding balance.

Should you need to cancel a session, please do so at least 48 **business hours** in advance. For instance, if you have an appointment on a Monday, please notify us by the end of business on Thursday if you need to change or cancel the appointment. If the 48 business hours in advance falls on a weekend or holiday, then cancellation needs to be made on the last business day before your appointment to avoid being charged your regular rate for the cancelled session.

The doctor's rate will be charged for all time commitments greater than five minutes including but not limited to making phone calls, writing reports or letters, and addressing insurance issues.

I agree in the event of non-payment to bear the cost of collection and/or court and legal fees, should this be required. I also agree to arbitration in the event of a dispute.

I have read and understood the foregoing, and I consent to this evaluation or treatment.

I have also read and fully agree with the HIPAA Privacy Practices Document.

_____ _____

Signed by Patient/Parent/Responsible Party Date

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310-820-3200

NEW PATIENT INFORMATION

Referred by: _____

Address: _____

_____

Phone: _____ **Account #**

PATIENT INFORMATION FOR MEDICAL RECORDS *(PLEASE PRINT)*:				**DATE:**
PATIENT:				
Mr. Mrs. Miss LAST NAME	FIRST NAME		MIDDLE	
PATIENT STREET ADDRESS	CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	DRIVERS LICENSE NUMBER	
PATIENT'S EMPLOYER			OCCUPATION	
EMPLOYER'S ADDRESS: STREET	CITY	STATE	ZIP	BUSINESS PHONE
SPOUSE'S NAME	MARITAL STATUS		REFERRED BY	
SPOUSE'S EMPLOYER: STREET ADDRESS	CITY	STATE	ZIP	BUSINESS PHONE
IN CASE OF AN EMERGENCY CONTACT: NAME	ADDRESS	CITY, STATE	ZIP	PHONE
MEDICAL INSURANCE INFORMATION:				
COMPANY	POLICY NUMBER			
COMPANY	POLICY NUMBER			
IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THE FOLLOWING SECTION:				
RESPONSIBLE PARTY:				
MR. MRS. MISS LAST NAME	FIRST NAME		MIDDLE	RELATIONSHIP
STREET ADDRESS	CITY	STATE	ZIP	HOME PHONE
OCCUPATION	EMPLOYED BY			BUSINESS PHONE
EMPLOYER'S STREET ADDRESS	CITY	STATE	ZIP	

I hereby authorize Dr. Vari to release any and all medical information to the above-named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I agree in the event of non-payment to bear the cost of collection and/or court costs and legal fees should this be required. I have read this authorization and understand it.

Insured or Guardian's Signature_____ Patient's Signature_____

Gabor Vari M.D.

MEDICAL EVALUATION

Patient's Name:

I. TO BE COMPLETED BY PATIENT

Please complete the following questions to the best of your ability

A. Identifying Data:

Name: _____ Home Phone: ( )_____

Address: _____ Marital Status _____

_____ Date of Birth ____/____/____

Zip Code MO DY YR

Occupation: _____ Work Phone: ( )_____

Educational Level: _____

B. What brings you in to see the doctor?

_____

_____

C. Personal Medical History:

1. Do you receive regular medical care from a physician or clinic? o No o Yes
   If yes, please provide the following information:

   Name of Physician or Clinic: _____ Phone ( )_____

   Address: _____
   (Zip Code)

2. Have you ever had any of the following illnesses?

	Yes	No		Yes	No
High Blood Pressure			Migraine Headaches		
Diabetes			Peptic Ulcers (stomach ulcers)		
Cancer			Colitis		
Thyroid Disease			Irritable Bowel Syndrome		
Other Hormone Problem			Tuberculosis		
Alcoholism			Stroke		
Heart Disease			Rheumatic Fever		
Glaucoma			Asthma		
Epilepsy			Birth Defects		

(a) Have you had any other disease? o No o Yes If yes, explain: _____

_____

_____

(b) What is your current weight (estimate if you do not know exactly)? _____ lbs.

C. Personal Medical History: (continued)

(c) What is the most you have ever weighed? _____ lbs. When? _____

(d) Can you explain any recent weight loss or weight gain? _____

_____

(e) What is your height? _____ ft. _____ in.

3. Have you ever had to be hospitalized? o No o Yes If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Reason

4. Have you ever had surgery or been advised to have surgery? o No o Yes If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Name of Operation or Procedure

5. Have you ever had any injuries?

	Yes	No	When	How did it happen?
Head Injury				
Concussion (ever been knocked unconscious)				
o Food o Chemical o Drug Poisoning				
Broken Bone				
Severe Cuts or Lacerations				
Other _____				

6. Do you have any allergies?

	Yes	No	How are you affected?
Penicillin			
Other Medication Allergies			
_____			
_____			
_____			

7. Have you recently had any of the following tests?

	Yes	No	When	Where	Results
Physical Exam					
Thyroid Blood Test					
Blood Tests					
Chest X-Ray					
TB Skin Test (PPD)					
Electrocardiogram (EKG)					
Brain Scan, MRI or Cat Scan					
EEG					

C. Personal Medical History: (continued)

8. Are you in the habit of using any of the following items?

	Amount Currently Using	Most Ever Used
Coffee (cups/day)		
Cigarettes (packs/day)		
Alcohol (amounts and types of alcohol used daily)		
Marijuana (joints/day)		
Vitamins		
Sleeping Pills		
Herbs		
Aspirin		
Laxatives or Diuretics		

9. Are you currently on any medication? o No o Yes If yes, please give name and dosage _____

_____

10. Have you ever used any of the following drugs or medications? (Circle the ones used)

	Yes	No	When	How Much
Dilantin, Tegretol, L-Dopa, Cogentin, Artane				
Valium, Librium, Serax, Dalmane, Tranxene, Ativan				
Sinequan, Tofranil, Elavil, Meprobarnate				
Lithium				
Thorazine, Mellaril, Stelazine, Navane, Haldol, Prolixin injection, Loxitane, Moban, Serentil				
Phenobarbital, Seconal, Tuinal, other barbiturates				
Amphetamines, Ritalin, other stimulants				
Heroin, Codeine, Methadone, Percondan, Dilaudid, Talwin, Darvon, Demerol				
Quaaludes, Placidyl, other sedatives				
Cocaine				
PCP				
LSD, Mushrooms, Psilocybin, other hallucinogens				
Other				

D. Family History

	Father	Mother	Brother			Sister			Spouse	Children					
			1	2	3	1	2	3		1	2	3	4	5	6
Age (if deceased give date and age at Death)															
Anxiety Disorder or Phobia															
Psychosis or Schizophrenia															
Shyness															
Obsessive Compulsive Disorder															
Manic Depression (Bipolar)															
Heart Attack or Heart Trouble															
Epilepsy or Convulsions															
Nervous Breakdown or Depression															
Alcoholism															
Suicide or Suicide Attempt															
Drug Abuse															
Hospitalization for Psychiatric Problem															
Thyroid Problem															

D. Family History (continued)

Attention Deficit Disorder															
Alzheimer's Disease															
Migraine Headaches															

E. Review of your current health:

1. Do you have?	Yes	No		Yes	No
Lumps anywhere			Unusual excessive thirst		
Double vision or poor vision			Urine problems, blood in urine		
Difficulty hearing			Indigestion, gas, heartburn		
Fainting spells, blackout spells			Stomach pain or stomach ulcer		
Convulsion			Diarrhea		
Paralysis			Constipation		
Dizziness			Vomiting, vomiting blood		
Headaches			Blood in stool		
Thyroid problem, goiter			Change in appetite or eating habits		
Skin problem			Trouble sleeping		
Cough or wheeze			Sexual problems		
Spitting up blood			Depression		
Palpitation or heart fluttering			Suicidal thoughts		
Chest pain			Weight loss or weight gain		

F. Review of your current health

	Yes	No		Yes	No
Shortness of breath at night or with mild exercise			Problems with memory, thinking or concentration		
Swelling of hands or feet			Weakness or tiredness		
Visual hallucinations			Joint pain		

Please describe or explain any of the positive answers above

_____

_____

_____

F. Review of your current health (continued):

2. For females only:

Date your last menstruation began: _____ Number of pregnancies _____

Number of children born alive: _____ Number of therapeutic abortions _____

Number of miscarriages or stillbirths: _____ Have you had a Pap smear within the last year? o No o Yes

Do you use any contraceptive method? o No o Yes If yes, what? _____

Do you examine your breasts for lumps? o No o Yes

Patient's Signature_____ Date_____

1) Have you ever taken any of the following Medication?

	YES	NO
a) Prozac (fluoxetine)	____	____
b) Wellbutrin (bupropion)	____	____
c) Anafranil (clomipramine)	____	____
d) Norpramin/Pertofrane (desipramine)	____	____
e) Pamelor (nortriptyline)	____	____
f) Buspar (buspirone)	____	____
g) Tegretol (carbamazepine)	____	____
h) Depakote/Depakane (valproic acid)	____	____
i) Desyrel (trazodone)	____	____
j) Asendin (amoxapine)	____	____
k) Xanax (alprazolam)	____	____
l) Klonopin (clonazepam)	____	____
m) Zoloft (sertraline)	____	____
n) Paxil (paroxetine)	____	____
o) Parnate	____	____
p) Marplan	____	____
q) Nardil	____	____
r) Effexor	____	____
s) Ambien	____	____
t) Risperdal	____	____
u) Serzone	____	____
v) Luvox	____	____
w) Lithium	____	____
x) Remeron	____	____
y) Lamictal	____	____
z) Neurontin	____	____
aa) Zyprexa	____	____
bb) Seroquel	____	____
cc) Clozapine	____	____
dd) Geodon	____	____
ee) Topamax	____	____
ff) Provigil	____	____
gg) Abilify	____	____
hh) Lexapro	____	____
ii) Cymbalta	____	____
jj) Emsam	____	____

2) Do you now or in the past:

	YES	NO
a) snore	____	____
b) jerk your arms/legs while asleep	____	____
c) gasp for breath during sleep	____	____
d) have creeping or crawling leg sensations	____	____
e) fall asleep suddenly during the day	____	____
f) wet the bed	____	____
g) walk or talk in your sleep	____	____

	YES	NO
3) Have you ever:		
a) binged on food uncontrollably	____	____
b) forced yourself to vomit food	____	____
c) used laxatives, water pills, diet pills, enemas or ipecac to lose weight	____	____
d) lost so much weight you stopped having your menstrual period	____	____
e) been told you are bulimic or anorexic	____	____
4) Do you ever have:	YES	NO
a) repetitive, unwanted thoughts	____	____
b) irresistible urges to check, count clean, touch or say things repeatedly	____	____
c) spasms, twitches or tics	____	____
5) While in school, did you:	YES	NO
a) have trouble sitting still in class	____	____
b) have trouble concentrating on school work	____	____
c) have trouble getting along with schoolmates	____	____
d) have anxiety about going to school	____	____
e) get left back or expelled	____	____
f) attend special education classes	____	____
g) have stutter, lisp	____	____
h) run away from home	____	____
6) Have you ever experienced	YES	NO
a) hearing voices when no one is around	____	____
b) watching things disappear, or change shape, color or position when this should not have occurred	____	____
c) unusual (rotten or fragrant) smells without anything to account for it	____	____
d) feelings of being touched without anyone or anything actually touching you	____	____
e) a sense of detachment from your surroundings	____	____
f) a feeling of unreality	____	____
g) periods of excessive energy, racing thoughts, diminished need for sleep, euphoria, spending sprees, increased sex drive, feelings of power	____	____
7) Have you ever had:	YES	NO
a) Hepatitis	____	____
b) Kidney disease/stones	____	____
c) Blood transfusions	____	____
d) Lyme disease	____	____

8) Have any of your family (parents, brothers/sisters, aunts/uncles, grandparents) had the following:

	YES	NO
a) Panic attacks	____	____
b) Autism	____	____
c) Epilepsy	____	____
d) Tourette's disease	____	____
e) Huntington's disease	____	____
f) Wilson's disease	____	____
g) Parkinson's disease	____	____
h) Porphyria	____	____
i) Anorexia or Bulimia	____	____

9) Have you ever been:

	YES	NO
a) in the military	____	____
if yes, dishonorably discharged	____	____
b) arrested for any reason	____	____
c) injured in an accident or war	____	____
d) subject to physical, sexual or verbal abuse	____	____
e) involved in a personal injury, workman's compensation or medical malpractice lawsuit	____	____
f) to your knowledge, have you been exposed to any toxic chemicals	____	____

10) Have you ever had the experience of:

	YES	NO
a) finding yourself in a place and having no idea how you got there	____	____
b) minutes, hours or days having gone by without any memory of what has happened during that time	____	____
c) having no memory for some important event in your life (for example, a graduation, wedding, death)	____	____

11) Do you ever have irresistible urges to:

	YES	NO
a) hurt, attack or kill someone	____	____
b) throw, break, destroy property	____	____
c) steal objects you don't need for personal use or monetary value	____	____
d) gamble, whether you can afford to or not	____	____
e) deliberately set fires	____	____
f) deliberately pull your hair out	____	____

12) Recent stressful life events (in last 2 years):

	YES	NO
a) marriage or engagement	____	____
b) separation or divorce	____	____
c) breakup of important relationship	____	____
d) death of close family, friend	____	____
e) child left home	____	____
f) bad health of family, friend	____	____
g) personal injury or illness	____	____
h) sexual difficulties	____	____
i) changes in school, work	____	____
j) changes in residence	____	____
k) financial difficulties	____	____
l) legal difficulties	____	____

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CREDIT CARD AUTHORIZATION

Provider Name: Gabor Vari, M.D.

Today's Date: _____

Patient's Name: _____

Phone Number: _____

( ) Visa ( ) Mastercard ( ) American Express

Name on Card _____

Credit Card Number: _____

Expiration Date: _____

Cardholder's Address: _____

City: _____

State: _____ Zip Code: _____

Security Code: _____
(3 digits on back of card or 4 on front for AmEx)

I understand that my credit card will be billed for office visits as well as for visits that are not changed or cancelled with 48 business hours notice.

Cardholder's Signature: _____

Cardholder's Name (please print): _____