The Vascular Birthmarks Foundation
with Dr. Stuart Nelson, Dr. Martin Mihm, and the Beckman Laser Institute
present the

Annual Vascular Birthmarks Conference and Clinic

California
October 10, 2015

Conference/Clinic Registration Form

Register now. Early registration ensures you a discounted hotel room and a clinic appointment.

Registration: 7:15AM

Conference – Opening Remarks 8:00AM, Speakers 8:30AM -12:30PM
At the Island Hotel, 690 Newport Center Drive, Newport Beach, CA 92660

Clinic Sessions-1:00 PM - 6:00 PM
At the Beckman Laser Institute, 1002 Health Sciences Road, Irvine, CA 92617

Section 1 – Contact Information

Please note there are two categories for attendees: 1) family/friends/guardians, and 2) attending physicians

Patient Information: Conference/Clinic fee $100 per family

Name of patient:____Age:_________Gender:_________

Name(s) of Parent/Guardian if patient is a minor: ____
____

Address____

Phone Numbers (How can we best reach you?)

(home)__________________________(work)____________________(cell)_____________________________

Email:___________________________________

Please include names and ages of siblings, family members or friends who will be joining you and the patient at the conference. For adults, please mark *adult* where it requests age.

Name____________________________________Age: ______ Relation to Patient:________________________

Name____________________________________Age: ______ Relation to Patient:________________________

Name____________________________________Age: ______ Relation to Patient:________________________

Name____________________________________Age: ______ Relation to Patient:________________________

Do you need a letter to the embassy for an entry visa? ___yes ___no

Attending Physician Information - This includes those who are speaking, administering clinic appointments, or attending. **-** Conference fee is $100.00 per physician. Ask about company sponsorship.

Name of Physician_______________________________________

Address____

Contact Info (How can we best reach you?) (email)_____________________________________

(home phone)________________(work)____________________(cell)__________________

Please include names and ages of family members, friends or associates who will be joining you. For adults, please mark *adult* where it requests age.

Name____________________________________Age:______________Relation to Physician:_____________

Name:____________________________________Age:_____________Relation to Physician______________

Section 2 – Lodging and Meals

Participants are responsible for their own lodging. Reservations at the Island Hotel must be reserved with a credit card. Use this booking link: https://resweb.passkey.com/go/VascularBirthmarksFoundation or call the hotel directly at 1-866-554-4620 and mention the Vascular Birthmarks Foundation Conference to receive the discount rate of $215 plus taxes.

The first 50 families who register for the conference AND have at least a one hour commute to the conference may request a free hotel room for Friday night only (incidentals not included). VBF will only pay for this one night and if you are one of the first 50 to register, you will receive a special access code to make your reservation. You must contact Carla at 610-301-4522 or carla@birthmark.org to confirm your request and provide a credit card number to secure the reservation. If you reserve a room and do not show or notify us to cancel, then your card will be charged.

PLEASE RESERVE AS SOON AS POSSIBLE TO ENSURE THIS OFFER.

The Continental breakfast and lunch are provided to all conference attendees free of charge.

Will you be attending the continental breakfast on Saturday morning? Yes No
# of adults_______age 13 and older # of children ____ age 13 and under

Will you have lunch on Saturday? Yes No
# of adults__________________aged 13 and up #______Regular #_____Vegetarian
# of children________________13 and under. #______Regular #_____Vegetarian

Section 3 - Clinic Registration/Information

Clinic appointments will be on **Saturday, October 10 from 1pm-6pm at the Beckman Laser Institute**, 1002 Health Sciences Road, Irvine, CA 92617 www.bli.uci.edu
Clinic appointments are available from 1:00 pm to 5:30 pm. Clinic appointments last about 15 minutes.
Note: For a Clinic Appointment, please send a photo of the patient clearly showing the birthmark. We must have a photo to properly schedule you with the most appropriate team. If you have any films, MRIs, x-rays or scans, please bring them to the clinic appointment along with photos that document the history of the birthmark. Do not mail imaging studies to VBF.

If you would like a clinic appointment, **mail or email a photo to carla@birthmark.org.**

___No, I only want to attend the conference. __Yes, I would like a clinic appointment.

Location of birthmark: ____

Briefly describe the birthmark and any treatment(s) to date:

____

____

Name of Patient's Current Physician____Phone Number:_______________

If possible, I would like an appointment at: ___________(approximate time).
If you have travel constraints, please write the **time you need to be seen** by in order to give you time to get to the airport or to meet other travel requirements:____

Please mark information below regarding clinic team.

Physicians: Please indicate the team on which you would like to work.

Patients: Please indicate which team you would like to see.

Clinic Teams: Place X next to team

Team		Physicians
1. Hemangiomas	___	Dr. Milton Waner, Dr. Teresa O
2. Malformations of the Head & Neck	___	Dr. Gregory Levitin, Dr. Raphael Ortiz, Dr. Doug Phillips
3. Malformations of Extremities (arms,legs)	___	Dr. Robert Rosen, Dr. Anton Hasso
4. PWS	___	Dr. Stuart Nelson, Dr. Martin Mihm
5. SWS	___	Dr. Anne Comi, Dr. Francine Blei, Dr. Anthony Chang
6. KTS	___	Dr. Kami Delfanian, Dr. Laura Findeiss, Dr. Deb Shatzkes

If you would like to see a particular physician, please write his or her name here: _________________________
Do you or anyone coming to the conference have special needs? This includes travel schedule constraints, health concerns or disabilities that require attention. Please explain here:

____

____

Section 4 - Daycare Services

Daycare services are available free of charge during the Saturday morning lectures from 8:30am to 12:30pm

Will you need daycare services? __Yes __ No.
Names and ages of children:

____

____

Section 5 – Special Sessions: Make-up, Psychotherapy, Insurance/Legal Sessions, and Patient & Family Discussion Sessions. Sessions take place between 1:00pm to 6:00pm.

Please indicate the number of people attending each session after Yes#.

Make-up: Yes # ______ No

Psychotherapy: Yes#______ No

Insurance: Yes #______ No

Dental/Orthodontic issues: Yes # ______ No

Family Support Group: Yes#______ No

If you have questions, please call Carla Mannix at 610-301-4522 or Carla@birthmark.org.

Section 6 - Permission to use images in media

TITLE OF PROGRAM: 2015 Vascular Birthmarks Conference

LOCATION: Conference at the Island Hotel, and Clinic at the Beckman Laser Institute

DATE OF PHOTOGRAPHS, VIDEO, OR INTERVIEWS: 10/10/2015

For good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, I hereby consent to the filming, photographing, recording, and interviewing of my appearance, poses, voice, and statements, and the editing thereof (hereafter collectively "my performance"), and my identification by name and biographical information, for the purpose of raising awareness about vascular birthmarks, tumors and related syndromes and in order to further the mission of the Vascular Birthmarks Foundation.

I acknowledge and agree that the Vascular Birthmarks Foundation shall have no obligation to use my photos, performance or name, that I shall not own any rights in my performance or in the work product, and that VBF shall be the sole owner thereof. I hereby forever release the Vascular Birthmarks Foundation from any right I may have in connection with the foregoing use of my images, performance, and name.

Note: Parents must sign for minors.

Name: ____ Signature: ________________________________

Address: ______________________________________

Phone: ____ Email: __________________________________

Minor's Name(s): ___________________________________ __________________________________

If you do NOT want your photo or video used by the media or by VBF, please sign here.

I do NOT give permission for my (or my minor's) photo or video to be used in any public media.

Name: ___________________________ Signature: _____________________________ Date: ___________

Section 7: Registration Fees

Registration Fee is $100.00 per family for the Conference/Clinic**.** Registration includes: Conference attendance to all sessions; free clinic appointment; continental breakfast & lunch for Saturday; free daycare during the Conference Sessions for children attending with families.
If you must cancel, see Section 8 for Refund Policy.

Make checks payable to *Vascular Birthmarks Foundation*. Total Amount enclosed: $__________ .

Note: All credit card transactions require full payment of $100. If you are unable to pay the fee due to financial hardship, check and sign below and complete the questions in Section 9.
Even if the conference fee is waived, a credit card is still required to reserve your room. If you reserve a room but don't show or don't notify us to cancel, your card will be charged.

Credit card type: __ MasterCard __Visa __Discovery __American Express

Credit card number:____Date of Expiration__________

Name as it appears on credit card___________________________________Amount:___________

Signature: ____

Hardship Waiver:

Families who have a financial hardship can ask for a waiver of fees. Please check below if you cannot afford to pay the balance of the clinic fees and sign your name:

___ I request a waiver of $________ of the fee: Signature________________________________Date_________

Please complete the questions in Section 9. Even if you are granted a waiver, your credit card number will still be held on file. If you reserve a free hotel room and do not check in for the Conference, your card will be charged $215 plus tax per night. **You must attend the Conference to receive a free room.** Please check-in at the Conference Registration Table to ensure that you are confirmed.

Section 8- Refund Policy

Credit card information is required to reserve your room. If you cancel on or before September 1, 2015 your full registration fee is refundable. If you cancel after September 1, but on or before October 1, 2015 you are eligible for a 50% refund. Cancellations after October 1, 2015 are non-refundable. There will be no refunds for anyone who cancels after that date.

NOTE: PLEASE MAKE A COPY FOR YOUR RECORDS

Please send registration form and fee as soon as possible to:
Vascular Birthmarks Foundation
P.O. Box 106
Latham, NY 12210

Thank You. Please keep the confirmation letter for admission to the conference. If you have any questions, contact Carla Mannix, Administrative Assistant at 610-301-4522 or Carla@birthmark.org.

VBF is a 501(c)(3) not for profit. ID# 16-1515227

Section 9 – Optional Questions – Waiver of Fee Request

Note: This section is **ONLY for a patient requesting a waiver of fees**. If you are requesting a waiver of conference fees, please answer the following

Name: ____

Gender: Select One: ____Male ____Female In what year were you born?________

Marital Status: Select One
Now married Widowed Divorced Separated Never married

Employment Status: Select One
Employed for wages
Self-employed
Out of work and looking for work
Out of work but not currently looking for work
A homemaker
A student
Retired
Unable to work

Housing - Is your house, apartment, mobile home… (select one)
Owned by you or someone in this household with a mortgage or loan?
Owned by you or someone in this household free and clear (without a mortgage or loan)?
Rented?
Occupied without payment of cash rent?

Household Income: What is your total household income? Circle One
Less than $10,000
$10,000 to $19,999
$20,000 to $29,999
$30,000 to $39,999
$40,000 to $49,999
$50,000 to $59,999
$60,000 to $69,999
$70,000 to $79,999
$80,000 to $89,999
$90,000 to $99,999
$100,000 to $149,999
$150,000 or more

Ethnicity: Select One
Hispanic or Latino Not Hispanic or Latino

Race: Select One (optional)
American Indian or Alaska Native
Asian or South-Asian
Black or African-American
Native Hawaiian or Other Pacific Islander
White or Caucasian
Other __________________________