Welcome To Our Practice

Thank you for choosing Indiana Vein Specialists® for your comprehensive vein care! We are committed to providing our patients with state-of-the-art venous treatment in a comfortable and friendly environment. Locally owned and operated, our office was founded on the guiding principles of respect and compassion for our patients.

The information contained is intended to assist you and save time during your visit with us. Please plan to spend about 60-90 minutes with us for your first visit. Optimally, make sure you are well-rested and hydrated for this evaluation. It is our goal to conduct a comprehensive review of your medical concerns in order to determine the proper treatment for you at this initial consultation and ultrasound evaluation. It is also our goal for you to leave our office with a full understanding of your treatment options and with all questions answered.

After we finish gathering all pertinent information, our team will review with you all findings and establish your treatment plan. We will discuss all treatments in detail, including benefits, risks, and alternatives. We will do our best to answer any questions you may have. All of our subsequent ultrasound testing and procedures are performed in office at our West/Carmel or East/Fishers locations. Please feel free to also review our website at www.indyveins.com and the patient education section at www.indyveins.com/procedure-videos/ prior to the visit, as well.

Once we have determined your individualized treatment plan, our staff will assist you with any appointment and treatment scheduling needs. They will also work to answer any insurance questions you may have. We request that you fill out the enclosed forms and bring them with you in order to expedite the time you spend with us.

We also request that you bring a pair of loose fitting shorts to change into for your visit and to arrive 20-30 minutes early to complete any additional paperwork. Please bring your insurance cards and photo identification with you. Our front office staff is prepared to make your visit pleasant and effective.

Thank you for selecting us,

Jeffery P. Schoonover, MD
Owner and Chief Medical Director

Natalie Gilman
Practice Administrator

O 317.348.3020 | F 317.863.1237
EAST: 11876 Olio Road, Suite 700, Fishers, IN 46037
WEST: 10483 Commerce Drive, Suite 100, Carmel, IN 46032

www.indyveins.com
INDIANA VEIN SPECIALISTS LLC
PATIENT REGISTRATION FORM

(PLEASE PRINT)

Referred By

Patient Information (To be completed by the Patient or Responsible Party)

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>St</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Phone</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drivers License Number</th>
<th>City</th>
<th>St</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse's Name</th>
<th>Spouse's Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To be Completed by Responsible Party (If other than patient)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Birthdate</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>St</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Phone</th>
<th>City</th>
<th>St</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Emergency Contact (Not Listed Above)

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Primary Insurance

<table>
<thead>
<tr>
<th>Copy of Insurance Cards Attached</th>
<th>Insurance Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Policy/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Secondary Insurance

<table>
<thead>
<tr>
<th>Copy of Insurance Cards Attached</th>
<th>Insurance Name</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Policy/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Email Addresses

<table>
<thead>
<tr>
<th>Home</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby authorize the above practice to disclose or receive any or all information relating to my evaluation at this office, including copies of my diagnostic test results, to or from my attending physician and/or such physicians as may be selected by my attending physician, at his or her discretion, for the purpose of obtaining further diagnosis and/or treatment which he or she believes is indicated.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance.

I understand that the above practice is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I understand that the above practice is not in the business of extending credit and I agree to pay the above practice at the time its bill is presented. If prompt payment is not made, the above practice may take action to collect its charges.

Signature ____________________________ Date ______________
Patient Health Questionnaire

Patient Name: _______________________________________________________

Please place a check mark on the symptoms you are experiencing:

☐ Aching
☐ Awakening at Night
☐ Burning
☐ Cold Leg
☐ Cramping
☐ Cramping in Leg
☐ Discoloration
☐ Heaviness
☐ Loss of Hair on Leg
☐ Pain
☐ Aching in Feet/Toes
☐ Bleeding from Veins
☐ Burning in Feet/Toes
☐ Color Change in Skin
☐ Cramping in Hip
☐ Difficulty in Healing Wounds
☐ Fatigue
☐ Itching
☐ Numbness
☐ Restless Legs

Please put a check mark on the white box if your main reason for visiting is Lower Extremity Complaints:

☐ Lower Extremity Complaints

Where are your symptoms located? Please choose all of the options that apply to you.

☐ In Both of My Legs
☐ In My Right Leg
☐ In My Left Leg
☐ I Have Symptoms in Locations Other Than My Legs
☐ Other

(If Both Legs) Where on your legs are your symptoms located?

☐ In My Thigh
☐ In My Knee
☐ Throughout My Whole Leg
☐ In My Calf
☐ In My Ankle
☐ Other

(If Right Leg Only) Where on your right leg are your symptoms located?

☐ In My Thigh
☐ In My Knee
☐ Throughout My Whole Leg
☐ In My Calf
☐ In My Ankle
☐ Other

(If Left Leg Only) Where on your left leg are your symptoms located?

☐ In My Thigh
☐ In My Knee
☐ Throughout My Whole Leg
☐ In My Calf
☐ In My Ankle
☐ Other
Patient Health Questionnaire

Patient Name: ____________________________________________

Please choose the statement below that best describes your symptoms in your right leg vs. the symptoms in your left leg.

☐ My symptoms are WORSE in my RIGHT leg
☐ My symptoms are WORSE in my LEFT leg
☐ My symptoms are EQUAL in BOTH of my legs

Do your symptoms bother you? Choose the best statement(s) below. Choose both options if both legs bother you.

☐ My symptoms bother me in my right leg
☐ My symptoms bother me in my left leg

How would you rate the severity of your symptoms in your right leg and left leg?

☐ I have MILD symptoms in my RIGHT leg
☐ I have MODERATE symptoms in my RIGHT leg
☐ I have SEVERE symptoms in my RIGHT leg
☐ I have MILD symptoms in my LEFT leg
☐ I have MODERATE symptoms in my LEFT leg
☐ I have SEVERE symptoms in my LEFT leg

Do you have any ULCERS on your legs? Please choose the best statement below.

☐ I do NOT have ulcers on either of my legs
☐ I have Ulcer(s) on my RIGHT leg
☐ I have Ulcer(s) on my LEFT leg

If you have Ulcers on your legs, please answer the following:

How long have you had an ulcer on your RIGHT leg?

☐ Less than 3 months
☐ 3 months
☐ 4 months
☐ 5 months
☐ 6 months
☐ 7 months
☐ 8 months
☐ 9 months
☐ 10 months
☐ 11 months
☐ 12 months
☐ More than 12 months

LEFT leg?

☐ Less than 3 months
☐ 3 months
☐ 4 months
☐ 5 months
☐ 6 months
☐ 7 months
☐ 8 months
☐ 9 months
☐ 10 months
☐ 11 months
☐ 12 months
☐ More than 12 months
Patient Health Questionnaire

Patient Name: ________________________________

How long have you been experiencing these reported symptoms?

☐ Days - Enter number: ________  ☐ Months - Enter number: ________
☐ Weeks - Enter number: ________  ☐ Years - Enter number: ________

When do you experience your symptoms? Please choose ALL that apply.

☐ Intermittently  ☐ While Lying Down  ☐ When Exposed to Warm Weather
☐ Mostly at Nighttime  ☐ At Bedtime  ☐ When Exposed to Cold Weather
☐ All Day  ☐ While Resting  ☐ Other
☐ Only During the Daytime  ☐ When Exposed to Cold Weather

What type of activities are AFFECTED by your symptoms? Please choose ALL that apply.

☐ Working  ☐ Inability to Climb Flights of Stairs  ☐ Heavy Lifting
☐ Traveling  ☐ Exercising  ☐ Rising Up From a Seated or Lying Position
☐ Grocery Shopping  ☐ Gardening  ☐ Other
☐ While Walking  ☐ Caring for My Family
☐ Daily Chores

What makes your symptoms that you experience WORSE? Please choose ALL that apply.

☐ Walking  ☐ Heat  ☐ Hot Baths
☐ Sitting for Long Periods of Time  ☐ Pregnancy  ☐ Traveling
☐ Premenstrual Cycle  ☐ Standing for Long Periods of Time  ☐ Other
☐ Exercising

What makes your symptoms that you experience BETTER? Please choose ALL that apply.

☐ Resting  ☐ Taking Breaks From Sitting  ☐ Taking Breaks From Standing
☐ Leg Elevation  ☐ Standing  ☐ Sitting
☐ Walking  ☐ Exercising  ☐ Warm Compresses
☐ Hot Baths

Have you tried COMPRESSION STOCKINGS to alleviate your symptoms? Please choose the best statement(s) below. Choose both, if they apply.

☐ I’ve tried stockings for my RIGHT leg  ☐ I’ve tried stockings for my LEFT leg
Patient Health Questionnaire

Patient Name: ____________________________________________

How often do you wear the compression stockings for your RIGHT leg symptoms? LEFT leg symptoms?

☐ I wear them intermittently on my RIGHT leg
☐ I wear them almost every day on my RIGHT leg
☐ I wear them all the time on my RIGHT leg

☐ I wear them intermittently on my LEFT leg
☐ I wear them almost every day on my LEFT leg
☐ I wear them all the time on my LEFT leg

Have you tried any other measures to assist in alleviating your symptoms?

☐ I have NOT tried any conservative measures
☐ Yes
☐ Other

What additional measures have you tried to improve your symptoms? Please choose ALL that apply.

☐ Leg Elevation
☐ Avoidance of Prolonged Sitting or Standing
☐ Walking
☐ Exercising
☐ Cold Soaks
☐ Medications
☐ Weight Reduction
☐ Warm Soaks
☐ Other

How long have you tried these various measures to alleviate your symptoms?

☐ Days - Enter number: _______
☐ Weeks - Enter number: _______

☐ Months - Enter number: _______
☐ Years - Enter number: _______

Did the various measures that you have tried IMPROVE your symptoms? Choose ALL that apply.

☐ I have NOT tried any conservative measures
☐ My symptoms IMPROVE but RETURN after using
☐ My symptoms HAVE Improved
☐ My symptoms HAVE NOT Improved

Please place a check mark on the vein procedures you have had in the past:

☐ Endovenous Laser Ablation
☐ Clarivein Ablation
☐ VenaSeal Ablation
☐ Ohmic Thermolysis
☐ Sclerotherapy for large veins
☐ Ultrasound-Guided Sclerotherapy
☐ Cosmetic Sclerotherapy
☐ Vein Stripping
☐ Vein Stent
☐ Other

☐ Radiofrequency Ablation
☐ Varithena Ablation
☐ Chemical Ablation
☐ Micro Phlebectomy
☐ Sclerotherapy for small veins
☐ Ultrasound Guided Foam Sclerotherapy
☐ Cosmetic Foam Sclerotherapy
☐ Vein Ligation
☐ Vena Cava Filter
Patient Health Questionnaire

Patient Name: ____________________________________________

Please place a check mark on any past vein related medical diagnosis that you have been treated for:
- [ ] Vein Thromboembolism
- [ ] Deep Vein Thrombosis (DVT)
- [ ] Leg Injury
- [ ] Kippel-Trenaunaya Syndrome
- [ ] Other
- [ ] Genetic Risk Factors
- [ ] Superficial Thrombophlebitis
- [ ] May-Thurner’s Syndrome
- [ ] Leg Ulcers

Please place a check mark on each of the medical conditions you have been diagnosed with:
- [ ] Anemia
- [ ] Aortic Aneurysm
- [ ] Arthritis
- [ ] Atherosclerosis
- [ ] Cancer
- [ ] Cold Sores
- [ ] Depression
- [ ] Heart Burn / Acid Reflux
- [ ] Heart Disease
- [ ] High Cholesterol
- [ ] Anxiety
- [ ] APLA
- [ ] Asthma
- [ ] Bronchitis / Emphysema
- [ ] Cirrhosis
- [ ] Crohn’s Disease
- [ ] Diabetes
- [ ] Gout
- [ ] Hepatitis
- [ ] HIV

Please place a check mark on the surgeries that you have had performed in the past:
- [ ] Appendix removal
- [ ] Bunion Repair
- [ ] Surgery to improve blood flow to the heart
- [ ] Removal of part of the colon
- [ ] Hernia repair
- [ ] Uterus removal
- [ ] Knee replacement
- [ ] Plastic surgery
- [ ] Skin cancer surgery
- [ ] Tonsils removes
- [ ] Breast surgery
- [ ] C-section
- [ ] Gallbladder removal
- [ ] Hemorrhoid removal
- [ ] Hip replacement
- [ ] Knee replacement
- [ ] Removal of part of the lung
- [ ] Prostate
- [ ] Thyroid surgery
- [ ] Other surgery

Please place a check mark on your current occupation status:
- [ ] My occupation requires sitting/standing
- [ ] Unemployed
- [ ] Employed Full-Time
- [ ] Retired
- [ ] My occupation requires me to be active
- [ ] Self-employed
- [ ] Employed Part-Time
- [ ] Other
Patient Health Questionnaire

Patient Name: ____________________________________________

Please place a check mark on your marital status:
- [ ] Married
- [ ] Divorced
- [ ] Divorced-Remarried
- [ ] Unmarried
- [ ] Widowed
- [ ] Widowed-Remarried

Please place a check mark on the number of children you have:
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] Several

Please place a check mark on your answer for if you consume alcohol:
- [ ] No
- [ ] Yes
- [ ] Other

Please place a check mark on any additional symptoms you are experiencing:
- [ ] Fatigue
- [ ] Chest Pain
- [ ] Abdominal Pain
- [ ] Ankle Pain
- [ ] Abnormal Numbness or Sensation
- [ ] Cold Intolerance
- [ ] Bleeding Tendencies
- [ ] Cold Sores
- [ ] Loss of Vision
- [ ] Palpitations / Irregular Heartbeat
- [ ] Decreased Vision
- [ ] Chronic / Frequent Cough
- [ ] Enlarged Prostate
- [ ] Skin Easily Bruises
- [ ] Anxiety
- [ ] Blood in Urine
- [ ] Hives
- [ ] Fever
- [ ] Hoarse Voice
- [ ] Cough / Spit Up Blood

Please list anything you are allergic to:
________________________________________________________________
________________________________________________________________
________________________________________________________________

Please list all medications that you are currently taking, including over-the-counter, vitamins and herbs:
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
Office Policies

Patient Name: (please print) ___________________________________________

Cancellation Policy
We make every effort to schedule your appointments according to your needs. Your appointment is time that we have set aside for you alone as we do not double book our appointments. We understand that sometimes things can come up or emergencies arise. Should you need to cancel or reschedule your appointment we would greatly appreciate at least a 48-hours’ notice. This allows us adequate time to possibly refill the appointment as well as reschedule your appointment for a time that will better fit your needs. A missed appointment or an appointment that is cancelled without a 48-hour notice will result in a $50.00 charge.

Insurance/Payment Policy
As a service to our patients, we will submit medical claims to your insurance company if applicable. Vein ablation, microphlebectomy, sclerotherapy, diagnostic procedures and compression stockings are usually covered by insurance. We will verify your plan benefits as a courtesy for you. If necessary, our office will prepare a written pre-certification or pre-determination. If a procedure is not covered by your policy, a cost estimate for non-covered services will be provided to you. Insurance providers do not “guarantee” the amounts quoted over the phone. We must emphasize that as a medical provider, our relationship is with you; not your insurance company. Your active participation is necessary when denials occur or payments are delayed from your insurance provider. The office will file all claims for procedures covered by Medicare or your commercial insurance policy. Please note that charges NOT covered by Medicare or your commercial insurance policy will be collected at the time of service. If you have secondary insurance, we will file claim forms for Medicare covered procedures with your secondary.

Please understand that although your insurance may “cover” the procedure(s), most patients will still have some out-of-pocket cost for each appointment, as insurance does not cover 100% of cost. By accepting insurance coverage you have entered into a contract with that company to accept responsibility for a certain percentage of the financial deductibles, co-pays and co-insurance amounts as outlined in the EOB’s (explanation of benefits) that we receive from your insurance company after a claim has been processed. We are enrolled in most major insurance plans and networks. However, if your enrollment is still pending for your plan, we will honor your insurance plan “in-network” benefit rates. If your individual/family deductible is $2,500 or higher, $500 will be due on the day of service of each endovenous laser ablation procedure.

In many cases your insurance company may cover all or a portion of the evaluation, diagnostics and procedures; however, we cannot guarantee this and you are responsible for payment of services rendered. A late charge of 1% will be added monthly to any patient-owned outstanding balance, not paid in full by the due date. If cost is the only thing standing in the way of your treatment, please ask to speak with the practice administrator. We are committed to working with our patients as much as possible in eliminating cost as a barrier to treatment. We accept cash, check, Visa, MasterCard, Discover and Care Credit™ as payment.

For those patients who are contracted with insurance carriers with whom we are an out-of-network provider, we will accept these insurances for payment but please realize that your choice to use an out-of-network provider for your treatment may affect your out-of-pocket costs.

We encourage you to contact your insurance company prior to your first procedure to ask for an estimate of your out-of-pocket costs. We will happily provide you with a list of procedure codes (CPT codes) for the procedures you need so that you can obtain as accurate an estimate as possible.

Agreement
I have read and acknowledge the policies above and agree to abide by the terms set forth in these policies.

Patient Signature ______________________________________________________ Date ____________________________

O 317.348.3020 | F 317.863.1237
EAST: 11876 Olio Road, Suite 700, Fishers, IN 46037
WEST: 10485 Commerce Drive, Suite 100, Carmel, IN 46032

www.indyveins.com
NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a “Notice of Privacy Practice” statement. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The health provider named above is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

TREATMENT
1. We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
2. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the healthcare provider named above.
3. It is our policy to provide a substitute health care provider, authorized by the healthcare provider named above to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.

PAYMENT
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to us for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

WORKERS’ COMPENSATION
We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

EMERGENCIES
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS
We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS
We may disclose your health information to coroners or medical examiners.

ORGAN DONATION
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES
We may disclose your health information for military, national security, prisoner and government benefits purposes.

CHANGE OF OWNERSHIP
In the event that the health care provider named above is sold or merged with another organization, your health information/record will become the property of the new owner.
**NOTICE OF PRIVACY PRACTICES**

**Marketing**
We may contact you for marketing purposes or fundraising purposes, as described below.

1. As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

2. It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Health Care provider sponsored fund-raising events. If we conduct fundraising and use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us.

3. We also provide educational and informative newsletters. We use communications like the U.S. Postal Service or electronic email for our newsletters—you have the right to opt-out of receiving such communications from us.

**Your Health Information Rights**

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the healthcare provider named above is not required to agree to the restriction that you requested.

2. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

3. You have the right to inspect and copy your health information.

4. You have a right to request that the healthcare provider named above amend your protected health information. Please be advised, however, that the healthcare provider named above is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your protected health information made by the healthcare provider named above.

6. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

1. The healthcare provider named above reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the healthcare provider named above is required by law to comply with this Notice.

2. The healthcare provider named above is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please call the office number listed at the top of this page.

**Complaints**

Complaints about your Privacy rights, or how the healthcare provider named above has handled your health information should be directed to Practice Privacy Officer by calling this office at the number noted at the top of this page. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

**Right to a Copy of This Notice**

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at (317)348-3023.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the healthcare provider named above with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient’s Name (print) ________________________________________________

Patient’s Signature ____________________________________________ Date_______________

I give Indiana Vein Specialists permission to send correspondence to my referring and primary care physician:

__________ YES   _________ NO   Patient Initials: ____________________________
HIPAA Contact List:

By default, Indiana Vein Specialists does not have permission to release any information to family or friends. If you would like additional people to assist in your care, please provide the following.

I, ____________________________ ____________________________, give permission to Indiana Vein Specialists to release the following information to the individuals listed:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Best Contact #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.  
☐ Medical History  ☐ Treatment  ☐ Appointment Times  ☐ Billing Information

2.  
☐ Medical History  ☐ Treatment  ☐ Appointment Times  ☐ Billing Information

3.  
☐ Medical History  ☐ Treatment  ☐ Appointment Times  ☐ Billing Information

4.  
☐ Medical History  ☐ Treatment  ☐ Appointment Times  ☐ Billing Information

I understand that I have the right to inspect and receive a copy of the information to be disclosed, and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization.

Patient Signature ____________________________ Date ___________
Directions to our EAST Office:
11876 Olio Road, Suite 700
Fishers, IN 46037

From the north: Take I-69 South to Exit #210. Go east (left) onto Southeastern Parkway, travel east .3 miles to the roundabout. Drive 1/4 of the turn onto Olio Road. You will then travel south on Olio Road for 1.7 miles. Indiana Vein Specialists® is on the west side of Olio (RIGHT-HAND), directly after the HSE Freshman Campus.

From the south: Take I-69 North to Exit #205. Go east (right) onto 116th Street and travel 5 miles to Olio Road. Turn north (LEFT) onto Olio Road. You will then travel 0.1 miles and Indiana Vein Specialists® is on the west (left) side of Olio, directly after FLIPPED OUT Hair Salon.

From the east: Take I-70 west and exit on Mt. Comfort Road, Exit #96. Go north (left) onto Mt. Comfort Road/N. County Road 600. Stay on this road as it turns into Olio Road. Your total distance from the I-70 exit to Indiana Vein Specialists® will be 10.1 miles. Indiana Vein Specialists® is on the west (left) side of Olio, directly after FLIPPED OUT Hair Salon.

From the west: Take I-70 east to 465 North/East to I-69 North to Exit #210. Take I-69 North to Exit #205. Go east (right) onto 116th Street and travel 5 miles to Olio Road. Turn north (LEFT) onto Olio Road. You will then travel 0.1 miles and Indiana Vein Specialists® is on the west (left) side of Olio, directly after FLIPPED OUT Hair Salon.

Directions to our WEST Office:
10485 Commerce Drive, Suite 100
Carmel, IN 46032

From the north: Take HWY 31 SOUTH to 106th Street, where you will turn RIGHT (west) onto 106th. You will continue on 106th Street, going through several roundabouts, for a total of 4.1 miles before turning LEFT (south) onto Commerce Drive. Indiana Vein Specialists® will be 0.1 miles on your LEFT directly before The Goddard School.

From the south & east: Take 465 North and exit onto Exit #27 Michigan Road/421 North, where you will turn RIGHT (north) onto Michigan Road. Continue north for one mile, going past Target. At the fourth stoplight, turn RIGHT (east) onto 106th Street. Drive 0.1 miles and then turn RIGHT (south) onto Commerce Drive. Indiana Vein Specialists® will be 0.1 miles on your LEFT directly before The Goddard School.

From the west: Take 465 North and exit onto Exit #27 Michigan Road/421 North, where you will turn LEFT (north) onto Michigan Road. Continue north for one mile, going past Target. At the fourth stoplight, turn RIGHT (east) onto 106th Street. Drive 0.1 miles and then turn RIGHT (south) onto Commerce Drive. Indiana Vein Specialists® will be 0.1 miles on your LEFT directly before The Goddard School.