Demetrios Karamichos, MD
RPVI, RVT, DABVLM

REGION VEIN
Better Options. Healthier Legs.®

Welcome To Our Practice

Thank you for choosing **Region Vein** for your care! We are committed to providing our patients with state-of-the-art 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.

Our team realizes that you have a choice for venous and lymphatic treatment options in Northwest Indiana. **Region Vein** is proud to be a leader in minimally invasive venous care. There are a variety of separate hospital-based practices in the area also offering venous treatment (i.e. vascular surgery and interventional radiology) which can be confusing for some patients. We emphasize that our independent practice is based on the American Venous and Lymphatic Society (AVLS) diagnostic evaluation and treatment standards, with exclusive focus on the office based/non-surgical approach to venous and lymphatic care. You can learn more about the AVLS here: **www.myavls.org/about-us.html** or **www.healthyveins.org**.

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 evaluation and potential 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 the office at our Munster location. Please feel free to also review our website at **www.RegionVein.com** 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.

Please 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. Insurance cards and photo identification will also be needed for the verification process. Our front office staff is prepared to make your visit pleasant and effective.

Thank you for selecting us,

Demetrios J. Karamichos, MD
Owner and Chief Medical Director

Rose Beccera
Office Manager

931 Ridge Road, Suite C, Munster, IN, 46321
O 219.595.3095 | 1.888.Leg.Vein F 219.881.8776
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REGION VEIN PC

PATIENT REGISTRATION FORM

(PLEASE PRINT) Referred By _____

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

Name _____ Sex _____ Age _____ Birthdate _____

Address _____ Marital Status _____

City _____ St _____ Zip _____ SSN _____

Home Phone _____ Employer _____

Work Phone _____ Address _____

Drivers License Number _____ City _____ St _____ Zip _____

Spouse's Name _____ Spouse's Employer _____

PCP _____

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

Name _____ Relationship to Patient _____

Address _____ Birthdate _____ SSN _____

City _____ St _____ Zip _____ Employer _____

Home Phone _____ Address _____

Work Phone _____ City _____ St _____ Zip _____

Emergency Contact (Not Listed Above)

Name _____ Phone _____

Primary Insurance

☐ Copy of Insurance Cards Attached

Insurance Name _____ Effective Date _____

Address _____ Policy/Group _____

_____ _____

Secondary Insurance

☐ Copy of Insurance Cards Attached

Insurance Name _____ Effective Date _____

Address _____ Policy/Group _____

_____ _____

Email Addresses

Home _____ Work _____

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 _____

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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

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

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

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Patient Health Questionnaire

Patient Name: _____

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 left?

- ☐ 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

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Patient Health Questionnaire

Patient Name: _____

How long have you been experiencing these reported symptoms?

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

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

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

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

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

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

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

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

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

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

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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

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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
- ☐ Klippel-Trenaunay 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
- ☐ Hypertension
- ☐ Anxiety
- ☐ APLA
- ☐ Asthma
- ☐ Bronchitis / Emphysema
- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Hepatitis
- ☐ HIV

Please place a check mark on each of the medical conditions FAMILY MEMBERS have been diagnosed with:

- ☐ Cancer
- ☐ Cardiac Disease
- ☐ Clotting Disorder(s)
- ☐ History of Blood Clots
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Diabetes
- ☐ Varicose Veins

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
- ☐ Removal of part of the lung
- ☐ Prostate
- ☐ Thyroid surgery
- ☐ Other surgery

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Patient Health Questionnaire

Patient Name: _____

Please List Occupation: _____

Please place a check mark on your current occupation status:

- ☐ My occupation requires sitting/standing
- ☐ My occupation requires me to be active
- ☐ Unemployed
- ☐ Self-employed
- ☐ Employed Full-Time
- ☐ Employed Part-Time
- ☐ Retired
- ☐ Other

Please place a check mark on your marital status:

- ☐ Married
- ☐ Unmarried
- ☐ Divorced
- ☐ Widowed
- ☐ Divorced-Remarried
- ☐ 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 your answer for if you currently smoke:

- ☐ Current - Every Day
- ☐ Former Smoker
- ☐ Current - Some Days
- ☐ Never Smoked

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

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Patient Name: _____

Please list anything you are allergic to:

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

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Region Vein - OFFICE AND FINANCIAL POLICY

Photo ID and Insurance Card:

❑ All patients will be required to present a valid driver's license or photo ID, their current medical insurance card and co-pay at every office visit. Patients without verifiable health insurance will be responsible for the payment for that visit.

Contact Information:

❑ Please ensure that your file is kept up to date with the best phone numbers, email and home addresses, and insurance information. Please inform the receptionist of any changes to your personal information upon arrival at the clinic or call after any of the above have changed.

Audio and Video Recording:

❑ **To protect the privacy of our patients and staff, NO audio or video recording is allowed.**

Safety:

❑ We understand that there are many reasons why you may need to visit our office and we will make every effort to make your visit(s) as pleasant and comfortable as possible. Our front desk and clinical staff are specially trained to assist, serve, and welcome our patients in a friendly, professional manner. In turn, we ask that your behavior is respectful to our staff. For the safety of our staff and patients, there is a zero tolerance policy for abusive/disruptive behavior of any kind and problematic behavior will lead to dismissal from the practice.

Appointment Acknowledgments:

❑ I acknowledge that Venous and/or Lymphatic Disease are chronic conditions. Treatment may require multiple visits. **Keeping your scheduled follow-up appointments and adhering to post procedure instructions are key to optimal outcomes.**

Cancellation Policy:

We strive to schedule our appointments so that each patient receives the right amount of time to be seen by our providers and staff. It is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy, and to help you remember you scheduled appointments, the team at **Region Vein** sends reminders by text and/or phone in advance of your appointment time.

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 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. This is a courtesy to our office as well as to those patients who are waiting to schedule with the providers.

❑ If you do not cancel or reschedule your appointment with **at least 24 hours notice**, you will incur a “NO-SHOW CHARGE” that must be paid prior to rescheduling. This is not payable by your insurance company and will be billed directly to you as follows:

$50 “No Show” for office visit

$100 “No Show” for treatment/procedure visit

Insurance Policy:

As a service to our patients, we will submit medical claims to your insurance company if applicable. Vein ablation, sclerotherapy, diagnostic procedures, wound care, lymphatic physical therapy, 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 typically 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.

❑ **PLEASE NOTE: COMPLIMENTARY/FREE “SCREENS” ARE NOT OFFERED AT OUR FACILITIES.**
If you are seeing a provider and being evaluated, this is considered an office visit and will be billed accordingly.

Stockings Policy:

❑ Insurers are quite variable as to requirements for using compression stockings prior to venous procedures ("conservative measures”), and our office will try to clarify these requirements and stockings coverage as much as possible. **Ultimately, if compression stockings are indicated and stockings are required/recommended, it will be the patient’s financial responsibility.**

Payment Policy:

❑ **If your individual/family deductible is $2,500 or higher, $500 will be due on the day of service of each 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-owed 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, checks, Visa, MasterCard, American Express 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.

❑ **As a reminder, all patients are expected to pay their statements in full by date due on the statement. Patient statements not paid within 90 days of their billed date may be transferred to a collection agency.** Payment plans are available for terms not to exceed 12 months. Please contact the practice administrator for this option if you are unable to pay in full for each statement to avoid being transferred to collections.

Estimates Policy:
Estimates for out-of-pocket costs for treatment are available. Any estimate is provided with the understanding that it is not a contract for the actual amount patients will be required to pay.

❑ **An estimate is our educated guess at what a service/treatment plan may cost - it is not binding and is subject to change.**
Estimates provided by **Region Vein** cannot and should not be relied upon as the actual charges and/or payments you will be responsible for paying, as the actual charges and/or payments may be either lower or higher than the estimate depending on a number of variables.

All estimates are based in part on information provided to us by insurance/third parties, and we cannot account for errors made by other parties. Additionally, we cannot predict or estimate for changes in treatment decisions, unforeseen complications, additional tests or procedures ordered by a provider, and your particular health care needs. The estimated patient cost may not include pre-procedure office visits, updated treatment plans, and post-procedure office visits that are not a part of routine care, or diagnostic testing.

Agreement

❑ I certify that the information I have provided to the practice is to the best of my knowledge, true and accurate.
I have read and acknowledge the policies above and agree to abide by the terms set forth in these policies.

Patient Signature (or Guardian Signature)

_____ Date_____

Region Vein
931 Ridge Road, Suite C
Munster, IN 46321
Office: 219-595-3095 Fax: 219-881-8776

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.

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INDIANA VEIN SPECIALISTS
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NOTICE OF PRIVACY PRACTICES

Marketing

We may contact you for marketing purposes or fund-raising 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 we 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 (219)595-3095.

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 Region Vein permission to send correspondence to my referring and primary care physician:

_____ YES _____NO Patient Initials: _____

Demetrios Karamichos, MD
RPVI, RVT, DABVLM

REGION VEIN
Better Options. Healthier Legs.®

HIPAA Contact List:

*By default, **Region Vein** 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 **Region Vein** to release the following information to the individuals listed:

Name	Relationship	Best Contact #
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.

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www.regionvein.com