CENTRAL INDIANA VEIN CENTER

WENDY J. RICH, M.D.
FICS, FACA

8103 Clearvista Parkway, Suite #225
Indianapolis, Indiana 45256

- Indianapolis (Community North campus)
- St. Francis (South campus)

Welcome and thank you for your interest in the ***Central Indiana Vein Center!!***

We would like to take this opportunity to tell you about Dr. Rich's practice and some important information.

MEET WENDY J. RICH, M.D.,

Wendy J. Rich, M.D. founded the Central Indiana Vein Center in 1995, and is the only practicing physician. Therefore, you will see Dr Rich at each appointment. Dr Rich graduated from Indiana University School of Medicine in 1989. She then went on to complete vein preceptorships in Greece, Australia, California, Kansas City, Jacksonville, and Orlando. She is a member of the North American Society of Phlebology, Fellow of the International College of Surgeons, and Fellow of the American College of Angiology.

Dr. Rich then joined the physicians at Iowa Vein Center where she completed a fellowship in the treatment of spider and varicose veins. She then returned to Indiana to open the Central Indiana Vein Center.

IMPORTANT INFORMATION:

Sclerotherapy (injection therapy) is the number one recommended treatment for spider veins. At your initial consultation Dr. Rich will offer you a treatment plan of Sclerotherapy sessions or you will be evaluated for additional testing (such as if you have larger varicose veins). Please be aware that each patient is different and at your consultation Dr. Rich will review an estimate of your costs. (Insurance will not cover spider vein treatments).

If Dr. Rich recommends Sclerotherapy as your best treatment, each session of Sclerotherapy will last for approximately 20-30 minutes. After each treatment you are asked to wear a pair of Gradient Compression Hose for 1-week (daytime only, the first 48 hrs being the most critical).

- Payment is expected at the time of treatment.
- We accept personal checks as well as Visa, MasterCard, American Express and Discover.
- In order to make the best use of our time, we ask that if you cannot make an appointment for ANY reason, please notify us as soon as possible. We generally have a cancellation list; so even though you cannot come, someone else may be able to.

- ***We look forward to seeing you at your first appointment!***

PHONE 317-570-7428 / OR 1-888-LEG VEIN
FAX 317-570-7420

Central Indiana Vein Center Wendy J. Rich, M.D.

PATIENT REGISTRATION:

LAST NAME: FIRST NAME: MIDDLE INITIAL:

HOME ADDRESS:

CITY: STATE: ZIP: HOME PHONE: ( )

DATE OF BIRTH: AGE: SEX: CELL PHONE: ( )

PRIMARY CARE PHYSICIAN: REFERRING DOCTOR:

REFERRING DR. ADDRESS: REFERRING DR. PHONE: ( )

SOCIAL SECURITY NUMBER:

PATIENTS EMPLOYER: OCCUPATION:

EMPLOYER ADDRESS: CITY: STATE: ZIP:

EMPLOYER PHONE NUMBER: ( ) EXT:

YOUR PREFERRED E-MAIL ADDRESS:

***YOUR MAIN TELEPHONE CONTACT NUMBER > FOR YOUR APPOINTMENT TIME AND OR EMERGENCY**

#

- **PLEASE DO NOT CONTACT ME →** ☐

SPOUSE OR RELATIVE:

SPOUSE NAME:

SPOUSE'S EMPLOYER: WORK PHONE: ( )

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU: PHONE: ( )

I hereby authorize payment directly to the Physician of the Medical or Surgical benefit, if any. Otherwise payable to me for his/her services as described, realizing I am responsible to pay any non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process claims.

PATIENT SIGNATURE: DATE:

8103 CLEARVISTA PKWY., SUITE # 225
INDIANAPOLIS, IN. 46256
317-570-7428

Central Indiana Vein Center

Wendy J. Rich, M.D.

PATIENT NAME: _____ **DATE:** ____/____/_____

Please check **yes** to any of the following that apply:

CARDIOVASCULAR	YES	NO
Heart Disease		
Coronary Artery Disease		
Congestive Heart Failure		
Arrhythmia (irregular beat)		
Valve Disease or Replacement		
History of Chest Pain		
PULMONARY		
Chronic Obstructive Disease		
Emphysema		
Tuberculosis		
Shortness of Breath		
Asthma		
RENAL / KIDNEY		
Renal Insufficiency		
Dialysis		
Kidney Stones		
GASTROINTESTINAL		
Hepatitis (Jaundice)		
Gall Stones		
Cirrhosis		
Ulcers		
NEUROLOGICAL		
Seizures / Epilepsy		
Stroke		
Migraine headaches		
Depression / Anxiety		
ENDOCRINE		
Diabetes		
Thyroid		
High Cholesterol		
GENERAL HEALTH		
High Blood Pressure		
Cataracts / Glaucoma		
Osteoporosis		
Arthritis		
Cancer		
AIDS or HIV		
Sun Sensitivity		
Number of Pregnancies:		
Number of Children:		
Are you pregnant now?		
Are you Breast Feeding?		

COMMENTS: _____

_____

_____

HISTORY OF VARICOSE AND SPIDER VEINS

When did you first notice enlarged veins? _____

Do your veins cause:

- Limited Activity _____
- Sharp Pain _____
- Aches / Discomfort _____
- Congestion _____
- Pressure _____
- Swelling _____
- Itching _____
- Redness _____
- Tightness _____

Have you had to take medication for leg pain _____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? PLEASE GIVE DATE.

- Clots in the Legs (Phlebitis) _____
- Clots in Lungs (Embolus) _____
- Deep Vein Thrombosis (DVT) _____
- Leg / Ankle Ulcers _____
- Taken a Blood Thinner _____
- Surgery in your Legs _____
- Major injury to Legs _____
- Leg Pain caused by walking _____
- Free bleeding from veins _____
- Weight change of 10 lbs in 6 mo. _____

Do you have a family history of vein disease? _____

_____

Have you ever had injection therapy (Sclerotherapy) in the past? _____

Do you or have you worn compression hose: _____

LIST ANY PREVIOUS SURGERIES: _____

LIST ALL CURRENT MEDICATIONS AND DOSAGE:

_____

LIST ANY DRUG ALLERGIES: _____

HEIGHT: ___ ft. ___ in. WEIGHT: ____ lbs. SHOE SIZE____

DRUG/ALCOHOL USE:

_____

TOBACCO USE: _____

LIST ANY HISTORY OF ANESTHESIA PROBLEMS:

_____

PATIENT SIGN: _____ M.D. REVIEWED: _____ DATE: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

This Notice takes effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

This notice describes the practices of ***The Central Indiana Vein Center*** employees and staff. Your health information will remain confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be ($ 1.00) for each page and the staff time charged will be ($ 25.00) per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Central Indiana Vein Center

8103 Clearvista Parkway, Suite # 225

Indianapolis, Indiana 46256

ATTN: Privacy Officer

Note: The Privacy Officer can be reached by telephone at (317) 570-7428.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We *The Central Indiana Vein Center* are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____ _____

Signature of Patient or Personal Representative *Date*

_____

If Personal Representative signature appears above, Please describe relationship to the patient.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

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SCLEROTHERAPY INFORMED CONSENT

Sclerotherapy is an effective method for eliminating varicose and spider veins, which is performed by injecting a small amount of a solution into the vein, which destroys the vessel. This procedure involves minimal pain, has few side effects, and will not require time off from work or your usual activities. The number of treatments required varies from patient to patient. Most patients experience good results after three to six treatments. In isolated cases two to three sessions may be adequate. After each session you will be required to wear dressings and compression hose for a period of time dependent on the extent of treatment. In addition, some bruising may be present for one to two weeks after treatment. Pre and post injection photographs will be taken and may be used for scientific presentations without identifying patient name.

Possible side effects include:

1. Mild itching which usually lasts one to two hours but may persist for a day or two.
2. Transient hyperpigmentation – Approximately ten percent of patients experience a discoloration the skin or light brown streaks in the treatment area. In many patients the treated vein becomes darker immediately after treatment. This discoloration fades over time and in rare instances may last up to four months.
3. Bruising as described above.
4. Ulceration or blistering may occur at the injection site, which may take one to two months to heal. This occurs in less than one percent of patients.
5. Ankle swelling may occur after injection of vessels in the foot or ankle area and usually resolves in a few days.
6. Pain is usually minimal however some patients may experience tenderness in the treatment area for few a days.
7. "Matting" refers to the development of very small blood vessels in the treatment area two to four weeks after treatment. This temporary condition usually resolves in four to six months and occurs in two to four percent of patients and up to eighteen percent of patients on estrogen.
8. Allergic reactions are very rare and occur more frequently in-patients with a history of allergies.

Patients can help avoid complications and facilitate better and faster results by wearing their dressings and compression hose as instructed and adhering closely to post injection instruction.

Patient Signature Date

Witness Date