LOWCOUNTRY VEIN SPECIALISTS, LLC
KARL HUBACH, MD
Office: 843-652-5344 | Fax: 843-652-0067 | 4545 Hwy. 17 Bypass Murrells Inlet, 29576

PATIENT INFORMATION (please print)

Legal First Name: _____ Legal Last Name: _____
Date of Birth ____/____/_____ Gender: Female/Male
Marital Status: ___Single ___Married ___Divorced ___Widowed
Cell Phone #: (_____) _____-_____ Home Phone #: (_____) _____-_____
Email: _____
Address: _____ Apt.#: _____
City: _____ State: _____Zip Code: _____
Employer: _____Occupation: _____

Primary Care Physician: _____ Phone #: (____) _____-_____
Address: _____ Fax Number: (_____)_____-_____

HOW DID YOU HEAR ABOUT US?

Doctor: Doctor's Name: _____
Friend: Friends Name: _____
Other: Please state other: _____
Reason for today's visit: _____

INSURANCE INFORMATION

Primary Insurance: _____Policy Holder's Name: _____
Policy Holder's Date of Birth: ___/___/_____ Relation to Patient: _____
Policy Number: _____ Group Number: _____
Secondary Insurance: _____Policy Holder's Name: _____
Policy Holder's Date of Birth: ___/___/_____ Relation to Patient: _____
Policy Number: _____ Group Number: _____

I authorize the release of any medical information necessary to process insurance claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I understand that I am responsible for payment of charges not covered by my insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

_____ _____
Signature of Patient or Patient's Representative Date

Emergency Contact Information

Name: _____Relationship: _____Phone # (____)___-____
Name: _____Relationship: _____Phone # (____)___-____

Your Personally Identifiable Information, also known as, Protected Health Information (PHI), as well as your medical records and billing information may need to be used or disclosed in order to carry out treatments, payments and healthcare operations by Lowcountry Vein Specialists (LVS).
LVS recommends that you review our Notice of Privacy Practices (NPP) that will be offered to you so you can have a thorough explanation of the potential uses and disclosures of such information.

Lowcountry Vein Specialists, LLC has my signed permission to share my Protected Health Information (PHI) and/or medical records - billing information to the following individual(s):

Name: _____
___ Share My Personal Health Information
___ Share My Medical Records
___ Share My Billing information
___ Share My Patient Visits
___ Share My Prescriptions

Name: _____
___ Personal Health Information
___ Medical Records
___ Billing information
___ Patient Visits
___ Prescriptions

_____ _____
Signature of Patient or Patient's Representative Effective Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(Separate Handout)

I Acknowledge that I have been provided a copy of South Carolina's Notice of Privacy Practices from Lowcountry Vein Specialists, LLC (LVS).
I understand that LVS has the right to change the Notice of Privacy Practices at any time, I will be provided a copy of the updated version, and I may contact LVS at any time to request a copy of the current Notice of Privacy Practices.

My signature below acknowledges that I have been provided a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Effective Date

_____

Print Name

_____

Relationship to patient (If not signed by Patient) _____

MEDICAL AND HEALTH HISTORY

Name: _____ Date: _____ Age: _____ Ht: _____ Wt: _____
When did you first notice enlarged, discolored or swollen veins? _____
Which leg bothers you the most? Left ____ Right ____ Both ____

Check all symptoms you are having:

__Aching	__Itching	__Sharp Pain	__Throbbing
__Burning	__Leg Cramps	__Spider Veins	__Leg Ulcers
__Fatigue	__Numbness	__Swelling	__Vein Rupture/Bleeding
__Heaviness	__Restless Leg	__Tenderness	__Redness/Discoloration

When did your symptoms begin? _____
Do your symptoms interfere with your daily activities? Yes / No
Have you ever used compression hose? Yes / No If so, how long? _____

Have you ever had:
Leg pain at night....Yes / No Leg pain caused by walking...Yes / No
Leg pain caused by standing....Yes / No Leg pain caused by sitting....Yes / No

Have you ever had:

Phlebitis (clots in legs).....	Yes / No	When?_____
Deep Vein Thrombosis.....	Yes / No	When?_____
Pulmonary Embolus (blood clot in lung)...	Yes / No	When?_____
Leg or Ankle Ulcers.....	Yes / No	When?_____
Painful Varicose Veins.....	Yes / No	When?_____
An ultrasound of your legs.....	Yes / No	When?_____
Bleeding from your Varicose Veins.....	Yes / No	When?_____

Have you ever smoked? Yes / No
Are you a current:
__Smoker __Tobacco user __Vape (E-Cig) user __Hookah Pen user
How many times in the past year have you had 5(men), 4(women) or more drinks in a day?_____

Do you have an Advanced Care Plan/Living Will?....Yes/No
Your Surrogate decision maker? Name_____ Relation_____

MEDICAL AND HEALTH HISTORY (continued)

Have you ever been pregnant? Yes / No
How many times? _____
How many deliveries? _____
Are you currently pregnant? Yes / No
List any hormones you are taking: _____
Are you taking Birth Control Pills? Yes / No

Are you able to walk for 20 minutes three times a day? Yes / No
Have you experienced a fall or problem with your gait or balance in the past two months? Yes / No
Have you ever had any of the following:

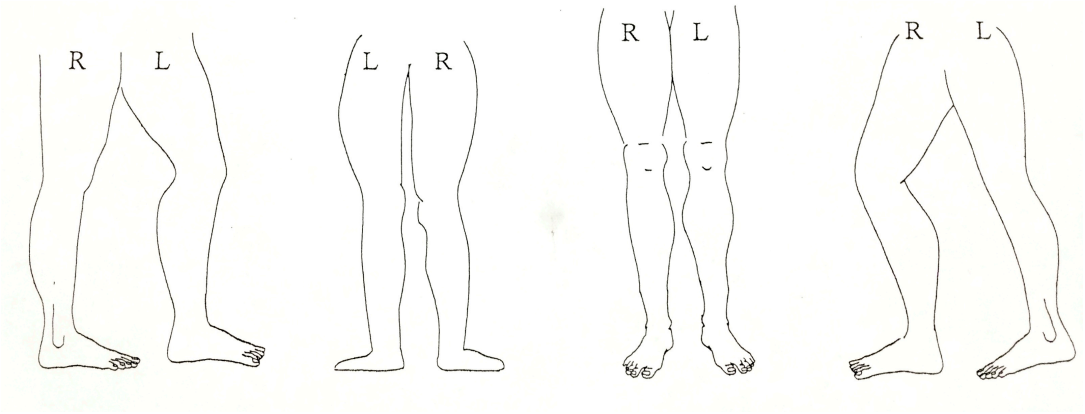
Aids or HIV positive.....Yes / No
Diabetes.....Yes / No
Migraine Headaches.....Yes / No
High Blood Pressure.....Yes / No
Heart Disease.....Yes / No
Jaundice or Hepatitis.....Yes / No
Cancer.....Yes / No
Recent Weight Change.....Yes / No
Major injury or surgery on you legs.....Yes / No
Clotting or blood problems.....Yes / No
Treatment for Varicose or Spider Veins.....Yes / No

Have you ever had sclerotherapy before?.....Yes / No
List any and all family members with vein problems:

_____

For Doctors Use Only

US: ___Yes ___No ___Right ___Left
Appt. for Sclero: ____Yes ____No



Medical and Health History (Continued)

List Any Allergies:

_____ _____ _____

_____ _____ _____

List all Surgeries:

_____ Date/Year _____

_____ Date/Year _____

_____ Date/Year _____

List any Current and/or Past Medical Problems/Conditions:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List All Medications you are currently taking (Including Non-Prescription):

Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____
Medication: _____ Milligrams: _____

To the best of my knowledge, the information and answers I have provided in the Patient Information form and Medical History form are accurate. I understand that providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the office of Lowcountry Vein Specialists (LVS) of ANY changes in my medical status. I authorize the healthcare staff at LVS to perform the necessary services I may need.

_____ _____

Signature of the Patient or Patient Representative Date

_____ _____

Signature of Physician Date

Financial Policies

Insurance Filing Policy

- Lowcountry Vein Specialists (LVS) will file insurance as a courtesy to the patient, as long as, LVS is in network with your insurance provider.
- If services provided are not covered by your insurance company, you will be responsible for payment at the time of service.
- Not all insurance companies pay for procedures performed in our office. Please be aware of your insurance policies as the payment for services are ultimately your responsibility.
- We will seek authorization and pre-approval for procedures, however, denials by your insurance company must be disputed by you.
- If we have not received payment from your insurance within 30 business days, you will be responsible for the balance due.
- Deductibles, co-payments, coinsurance, and past due balances will be collected at the time of service.

Self Pay Patients

If you are a self-pay patient, you will be required to pay your balance in full at the time of service.

Cancelled and Missed Appointments

- Lowcountry Vein Specialists (LVS) understands that situations arise in which you must cancel your appointment. As a courtesy to other patients who need to be seen, please give as much notice as possible so we may offer them your appointment time.
- If you repeatedly fail to show for your appointments, LVS reserves the right to bill you for the cost of the appointment type and to refuse future appointments.

Check Policy

- If your check is returned, the amount will be re-applied to your account with an additional $25 fee and LVS will no longer accept payments from you via check.

Collection Agency Policy

- You are responsible for payment of services provided by our office.
- If you have a delinquent account and it is turned over to a collection agency, you will be responsible for all cost and fees (45% collection fee/interest) related to the collection, as well as, the amount due on your account.

_____ _____

Signature Of Patient or Legal Guardian Date

South Carolina Department of Health and Environmental Control

Notice of Privacy Practices

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.**

Our Pledge Regarding Your Health Information:

DHEC is committed to protecting the privacy of your health information. We create a record of the health care and services you receive in order to provide you with quality care and to comply with legal requirements.

This Notice explains how we may use or release your health information, our obligations related to the use and release of your health information, and your rights regarding your health information. We are required by law to make sure that health information that identifies you is kept private, to give you this Notice of our legal duties and privacy practices with respect to your health information, to follow the terms of our current Notice, and to notify you in case of a breach of your unsecured protected health information.

This Notice applies to all of the records of your care generated by DHEC, whether made by clinic personnel or another health care provider. The practices described in this Notice will be followed by all DHEC clinics, any member of a volunteer group we allow to help you while you are in this facility, and all employees, staff and other DHEC personnel.

If you have any questions about this Notice of Privacy Practices, please contact:

DHEC Privacy Officer
South Carolina Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201
(803) 898-3318 or compliance@dhec.sc.gov

How DHEC Uses and Releases Health Information

The following categories describe different ways DHEC uses and releases health information.

- **For Treatment.** We use your health information to provide you with medical treatment or services. We may release your health information to caregivers such as doctors, nurses, technicians, medical students, or other clinic or DHEC personnel who take care of you. We also may release information to persons outside of DHEC who assist in your care such as family members or other healthcare providers. For example, a doctor treating you for an injury may need to know about your diabetes for treatment purposes. Different divisions or departments of DHEC may also share health information about you in order to coordinate your different needs, such as prescriptions, lab work and referrals.
- **For Payment.** We may use and release your health information to bill and collect payment for your treatment and services from an insurance company or a third party, or to obtain prior approval for treatment from your health plan. For example, we give health information about you to your health insurance plan so it will pay for your services.
- **For Health Care Operations.** We may use and release your health information for healthcare operations necessary to run the clinic and make sure that all of our patients receive quality care. For example, we may combine health information about many clinic patients to decide what additional services we should offer, what services are not needed, and whether new treatments are effective. We may disclose information to doctors, nurses, technicians, medical students, and other clinical personnel for review and learning. We may remove information that identifies you from this medical information so others may use it to study health care and health care delivery without learning who you are.
- **Research.** Under certain circumstances, we may use and release your health information for research purposes. For example, a research project may compare the health and recovery of all patients who received one medication to those who received another medication for the same condition. All research projects must first be approved through a special evaluation process to balance the research needs with your need for privacy.
- **As Required By Law.** We will release your health information when required to do so by federal or state law.
- **To Avert a Serious Threat to Health or Safety.** We may use and release your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

Use and Releases of Your Information In Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release your health information as necessary to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.
- **Specialized Government Functions.** We may disclose your health information for specialized government purposes, including military and veterans' activities, national security and intelligence activities, protective service of the President and others, medical suitability determinations for Department of State officials, correctional institutions and law enforcement custodial situations, or for the provision of public benefits.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Activities.** We may release your health information for public health activities to prevent or control disease, injury or disability; to report vital events such as births and deaths; to report immunizations to the state registry; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of product recalls; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority of suspected abuse, neglect or domestic violence as required or authorized by law.
- **Health Oversight Activities.** We may release your health information to a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensing.
- **Lawsuits and Disputes.** We may release your health information in response to a court or administrative order or in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement.** We may release health information to a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - If you are the victim of a crime, with your agreement or, under certain circumstances, if we are unable to obtain your agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the clinic or health department; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner, for example, to identify a deceased person or determine the cause of death, or to funeral directors as necessary to carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official if the release is necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.
- We may keep your health information in electronic form and share it with other health care providers through a health information exchange, unless you request that we not do so.
- We will not use or release your health information for purposes of marketing or fund-raising activities. We will not use or disclose psychotherapy notes without your written authorization (with limited exceptions for certain treatment, payment or health care operations). We will not sell your health information.
- Under South Carolina law, we must not release your medical records without your written consent, except as otherwise provided by law. We must also comply with additional restrictions on certain types of information, including information relating to sexually transmitted disease, HIV, TB, other communicable diseases, family planning, WIC, drug control, substance abuse, and mental health.

We will not release STD/HIV information except:

- For statistical purposes in a manner that no individual person can be identified;
- With the consent of all persons identified in the information released;
- To the extent necessary to enforce state laws and regulations concerning the control and treatment of STD;
- To medical personnel to the extent necessary to protect the health or life of any person;
- In cases involving a minor, the name of the minor and medical information concerning the minor must be reported to appropriate agents if a report of abuse or neglect is required by state law; or
- If a minor has AIDS or is infected with HIV, and is attending a public school in kindergarten through fifth grade, we will notify the superintendent of the school district and the nurse or other health professional assigned to the school the minor attends.

Your Health Information Rights

You have the following rights regarding the health information DHEC has about you:

- **Right to Inspect or Obtain a Copy of Your Health Information.** You may request a copy of your health information, including medical, billing, or health care payment information, from the local health department. This right includes obtaining copies of test reports directly from the processing laboratory. Upon request, we will provide you with the name of the laboratory.

  To access your health information, including any test reports processed by DHEC's Bureau of Laboratories, you must submit a written request. DHEC's local health departments or Bureau of Laboratories can provide you with an Authorization to Release Health Information, if requested. Under certain circumstances, you may be asked to provide proof of identity to obtain your health information.

  If we keep your health information in an electronic record, and you request an electronic copy, we will provide the information to you in the electronic form and format you request if it is readily producible. If it is not, we will provide the information to you in a readable electronic form and format as agreed by you and us. If you direct us to, we will transmit your information directly to a person or entity you designate. We may charge a reasonable, cost-based fee for copying, mailing, and supplies associated with your request, including the cost of portable electronic media if you request your information in that form. We will respond to all valid requests for health information within thirty days or notify you of our inability to do so.

  In limited cases, we may deny your request. If your request is denied, you may request a review of the denial.

- **Right to Amend.** If you believe your health information is incorrect or incomplete, you may ask us to amend the information by sending a request in writing to the Privacy Officer stating the reason you believe your information should be amended. We may deny your request if you ask us to amend information that was not created by us; is not part of the health information kept by or for DHEC; is not part of the information you would be permitted to inspect and copy; or your health information is accurate and complete. You have the right to request an amendment for as long as DHEC keeps the information.
- **Right to an Accounting of Releases.** You have the right to request a list of the releases we have made of your health information. This list will not include health information released to provide treatment to you, obtain payment for services, or for administrative or operational purposes (except releases through an electronic health record we have made of your information in the three years before your request); releases for national security purposes; releases to correctional or other law enforcement facilities; releases authorized by you; releases to persons involved in your health care; and releases made more than six years before your request.
- You must submit your request in writing to the Privacy Officer, stating a time period that may not go back further than six years. Your request should indicate in what form you want the list (for example, by paper or electronically). The first list you request within a 12- month period will be free. We may charge you for the cost of providing additional lists. If so, we will notify you of the cost and you may withdraw or modify your request before any costs are charged to you.
- **Right to Request Restrictions.** You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend. For example, you may ask that we not use or disclose information about an immunization or particular service you had. You may request that we not share your information through an electronic health information exchange.
- *We are not required to agree to your request unless you have paid in full for a health care item or service "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes*. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Appoint a Representative.** You have a right to give someone else authority to make decisions about your health information, such as a power of attorney or medical power of attorney. If someone is your legal guardian, that person can also exercise rights and make choices about your health information.
- **Right to a Paper Copy of This Notice.** You have the right to request a paper copy of this notice at any time by contacting the Privacy Officer named in this Notice. You may obtain a copy of this notice at our website: www.scdhec.gov

Changes To This Notice

We reserve the right to change this notice. We may make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in DHEC clinics and other facilities. The notice will contain on the first page, in the lower right-hand corner, the effective date. In addition, each time you receive treatment or health care services at any DHEC clinic, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the DHEC Privacy Officer or with the Department of Health and Human Services Office of Civil Rights. To file a complaint with DHEC, submit your complaint in writing to the Privacy Officer at the address listed on the first page of this Notice. To file a complaint with the Office of Civil Rights, submit your complaint in writing to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. • Room 509F HHH Bldg
Washington, DC 20201
Customer Response Center: 1-800-368-1019
Fax: (202) 619-3818 • TDD: 1-800-537-7697 • Email: ocrmail@hhs.gov

You will not be penalized or retaliated against for filing a complaint.

Other Uses Of Health Information

This Notice describes and gives some examples of the permitted ways your health information may be used or released. We will ask for your written permission before we use or release your health information for purposes not covered in this Notice or required by law. If you provide us written permission to use or release information, you can change your mind and remove your permission at any time by notifying the Privacy Officer in writing. If you remove your permission, we will no longer use or release the information for that purpose. However, we will not be able to take back any release that we made with your permission, and we are required to retain our records of the care that we provided to you.