Denver Vein Center | Aesthetic Laser Specialists | Surg One

www.denvervein.com

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Dear New Patient,

Welcome to our practice! Attached are forms for you to fill out prior to your first appointment. Please be sure to bring them in with you to avoid filling them out twice. There is an Acknowledgement of Privacy Practices that you will need to sign. Copies of the Privacy Practices are available online or in the office, please let the front desk know if you would like a copy.

We will also need a copy of your Driver's License on the day of the appointment.

We look forward to meeting you! Please don't hesitate to call with any questions.

Sincerely,

Denver Vein Center Staff

401 W Hampden Place, Suite 250, Englewood, CO 80110
303-777-VEIN (8346)
303-777-8377 Fax

Denise C. Norton, M.D.
401 W. Hampden Place, Suite 250, Englewood, CO 80110
(303)777-8346

PATIENT INFORMATION

How did you hear about us?_____

Email:_____

Name (Legal): ***Last***:_____ ***First***:_____ ***M.I.***____ Nickname:_____

Address:_____***City***:_____***State***:_____***Zip***:_____

Sex: M / F ***Marital Status***: S / M / W / D ***Date of Birth***: _____ _____ _____
MM DD YYYY

Race: _____ ***Ethnicity:*** _____ ***Language Spoken at Home*** _____

Phone: ***Home*** ( ) _____ ***Work*** ( ) _____ ***Cell/Pager*** ( ) _____

Emergency Contact: Relative/Friend, **not living with you** (In case we are unable to contact you, or need to contact someone regarding your care in an emergency).

Contact: _____ Phone #:_____ Relationship to Patient:_____

Address: _____ City: _____State:_____ Zip:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES THE DAY OF SERVICE. THESE SERVICES ARE NOT COVERED BY INSURANCE.

X_____(Signed) Date:_____

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MEDICAL HISTORY FORM

Do you currently have or have had any of the following?

» Cryoglobulinemia (a condition in which an abnormal level of proteins thicken the blood in cold temperatures), or paroxysmal cold hemoglobinuria or cold agglutinin disease (blood disorders in which cold temperatures lead to red blood cell death)…….**Yes / No**

» Known sensitivity to cold such as cold urticaria (hives triggered by cold), Raynaud's disease (disorder in which cold leads to reduced blood flow in the fingers, which appear white, red, or blue), pernio or Chilblains (itchy and/or tender red or purple bumps that occur as a reaction to cold). ……**Yes / No**

» Poor blood flow in the area to be treated……**Yes / No**

» Neuropathic (nerve) disorders such as post-herpetic neuralgia or diabetic neuropathy……**Yes / No**

» Impaired skin sensation ……**Yes / No**

» Open or infected wounds ……**Yes / No**

» Bleeding disorders or use of blood thinners ……**Yes / No**

» Recent surgery or scar tissue in the area to be treated……**Yes / No**

» A hernia or history of hernia in the area to be treated or adjacent to treatment site ……**Yes / No**

» Skin conditions such as eczema, dermatitis, or rashes……**Yes / No**

» Pregnancy or lactation (making breast milk or breast feeding) ……**Yes / No**

» Any active implanted devices such as pacemakers and defibrillators ……**Yes / No**

» Any major health problems such as liver disease ……**Yes / No**

» Any known sensitivity to isopropyl alcohol (rubbing alcohol) or propylene glycol ……**Yes / No**

List all prescription & non-prescription medications you are taking and doses: (use back of page if you need more room)

1._____ Dose_____ Reason_____

2._____ Dose_____ Reason_____

Do you have any allergies? Please List_____

List all Current Medical Problems

1._____

2._____

List all Surgeries and dates

1._____

2._____

Height:_____ Weight:_____

Print Name: _____ Signature:_____ Date: _____

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Denver Vein Center Aesthetic Laser Surg One

PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name:

I, _____, authorize Denver Vein Center, Dr. Denise Norton and staff representatives, to take photographs of my body for medical purposes to be used for my patient care, marketing, literature and/or case presentations.

I understand that:

» Photographs are taken to capture treatment outcomes for the CoolSculpting® procedure.

» They may be used for print, visual or electronic media including but not limited to, scientific presentations, websites and for purposes of informing the medical profession or general public about the procedure. These uses may also include marketing on behalf of Denver Vein Center.

» The images taken of me may be published by Denver Vein Center and its agents.

» I will not be identified by name in any of the published materials.

» My face will not be shown in the photographs nor will they reveal my identity.

» I have the right to revoke this authorization in writing at any time through a written revocation to Denver Vein Center.

I hereby release Denver Vein Center, Denise Norton, MD and its agents from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms. If I have any questions I can contact Denver Vein Center at 303-777-8346.

If under 18, guardian or parent must sign.

Print Name: _____ Signature: _____ Date: _____

Witness: _____ Date: _____

SurgOne, P.C.

Protected Health Information and Communication Consent

Your physician and/or the staff may at times need to contact you and/or discuss your care with those persons whom you give us consent to do so. By completing the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy regarding leaving medical care messages and/or discussing your care with others:

- We will ***NOT*** leave messages on voice mail or answering machines ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.
- We will ***NOT*** discuss your care with others ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.

PATIENT NAME: _____ Birth Date:_____

	May we leave a message?		May we discuss your care?	
HOME PHONE:_____	Yes	No	Yes	No
WORK PHONE:_____	Yes	No	Yes	No
CELL PHONE: _____	Yes	No	Yes	No
EMAIL*:_____			Yes	No

(*Please note that most standard email addresses (yahoo, comcast, hotmail, aol, etc)are not secure/HIPAA compliant. By writing in your email above and circling YES, you are giving us permission to contact you via unsecure email).

Please carefully consider with whom we may leave messages and/or whom you wish to have us communicate with in regards to your medical and/or billing information:

Spouse or Partner	Yes	No	If yes, name:_____
Son or Daughter	Yes	No	If yes, name:_____
Mother or Father	Yes	No	If yes, name:_____
Friend/Neighbor	Yes	No	If yes, name:_____
Other	Yes	No	If yes, name:_____

Notes:_____

Voice mail or answering machine messages may include the following information:

Specific information regarding my surgery/treatment	Yes	No
Scheduling for Lab/Test/Surgery	Yes	No
Results for Lab/Test/Surgery	Yes	No

I fully understand that this consent will remain valid until revoked in writing by me.

SIGNATURE:_____ **DATE:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I am in receipt of the Notice of Privacy Practices for SurgOne, P.C.

_____

Print Name

_____ _____

Signature Date

Denise Norton, MD
401 W. Hampden Place, Suite 250
Englewood, CO 80110
(303) 777-8346

Denise Norton, MD

Denver Vein Center/SurgOne, P.C. Cancellation Policy

At Denver Vein Center (a division of SurgOne, P.C.), we strive to render care in a timely and prompt manner. When a patient misses a scheduled appointment, or cancels an appointment with minimal notice, not only is that time lost, but it negatively impacts our ability to schedule other patients that require medical care. As a general rule, any patients that are more than 10 minutes late to their appointment will need to reschedule. Occasionally we will be able to accommodate the appointment, so call if you are running late. Denver Vein Center (a division of SurgOne, P.C.) has thus adopted the following Cancellation Policy. By signing below, you hereby acknowledge and agree to the following:

- Any patient that fails to show up for a scheduled appointment, or cancels a scheduled appointment with less than 48 hours' notice, will be charged a Cancellation Fee.

- Cancellation Fees can range from $25.00 up to $200.00 depending on the length of the appointment and the specialty of the provider with whom it was scheduled. SurgOne can provide the exact amount of a Cancellation Fee at the time an appointment is scheduled.

- All outstanding Cancellation Fees must be paid in full prior to the scheduling of a patient's next appointment with Denver Vein Center.

- Patients are solely responsible for the payment of Cancellation Fees, not insurance companies, Medicare, or other third-party payers.

- Any patient who, in a given 12-month period, misses three or more scheduled appointments, or cancels three or more scheduled appointments with less than 48 hours' notice, may be dismissed as a patient from Denver Vein Center.

I have read and understand the above Denver Vein Center Cancellation Policy and I agree to be bound by its terms.

_____
Patient Signature

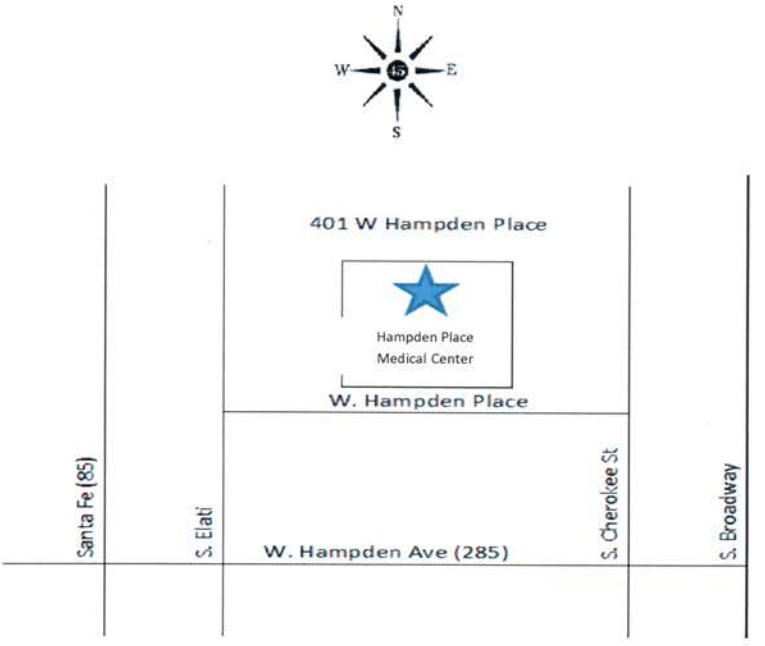
_____
Patient Name

_____
Date

401 W Hampden Place

Suite #250

Englewood, CO 80110



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