EVEXIAS
MEDICAL CENTERS

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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,

Evexias Medical Denver Staff

401 W Hampden Place, Suite 250, Englewood, CO 80110
(720) 625-8043 Phone
(720) 777-8377 Fax
www.evexiasdenver.com

Denise C. Norton, M.D.
401 W. Hampden Place, Suite 250, Englewood, CO 80110
(720)625-8043

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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PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name:

I ❑ Authorize ❑ DO NOT authorize Evexias Medical Denver, Dr. Denise Norton and staff representatives, to take photographs of my body for the following:

❑ Medical purposes to be used for my patient care (and to show treatment outcomes)
❑ 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 Evexias Medical Denver.

» The images taken of me may be published by Evexias Medical Denver 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 Evexias Medical Denver, 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 Evexias Medical Denver at (720) 625-8043.

If under 18, guardian or parent must sign.

Print Name: _____ Signature: _____ Date: _____

Witness: _____ Date: _____

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Denise Norton, MD

Denver Vein Center/Evexias Medical Center, P.C. Cancellation Policy
Effective July 15, 2019

At Denver Vein Center/Evexias Medical Center 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 may need to reschedule. Occasionally we will be able to accommodate the appointment, so call if you are running late. 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 2-business days' notice, will be charged a $50 cancellation Fee.
- Surgeries cancelled with less than 2-weeks' notice will be charged $200. This is due to time constraints in getting prior authorization.
- All outstanding Cancellation Fees must be paid in full prior to the scheduling of a patient's next appointment with Denver Vein Center/Evexias Medical 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 2-business days' notice, may be dismissed as a patient from Denver Vein Center/Evexias Medical Center.

I have read and understand the above Denver Vein Center/Evexias Medical 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
(720)625-8043 or (303)777-8346
www.evexiasdenver.com or www.denvervein.com

EVEXIAS MEDICAL DENVER/DENVER VEIN CENTER

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 CAREFULLY.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care

Our Uses & Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- As required for billing insurance for services
- Comply with Law and help with public health and safety issues
- Address workers' compensation law, law enforcement, and other government requests
- Respond to lawsuits and legal actions

PHI Consent

I consent Evexias Medical/Denver Vein to leave detailed messages regarding my healthcare, appointments, services, diagnostic test results, financial services and special offers on the following:
Phone: _____ Voicemail / Text (please circle all that apply)
Email: (Print please)_____

I give consent to Evexias Medical Denver to release my protected health information (PHI) to include but not limited to: physical exam results, lab results or other diagnostic studies, medication information/changes, appointments, billing information to the following people:

Name:_____Phone#:_____

Signature

This consent will expire with the written notification to info@evexiasdenver.com

Signature:_____Date_____