401 W Hampden Place, Suite 250
Englewood, CO 80110
(720)625-8043
(720)619-6098 TEXT

www.denvervein.com
www.evexiasdenver.com

WELCOME TO OUR PRACTICE!

We would like to communicate some expectations to you in advance:

- Every patient will be expected to complete our Patient Information, Patient Medical History, Cancellation Policy and HIPAA Privacy Practices forms. Copies of the HIPAA Privacy Practices are available online or in the office, please let the front desk know if you would like a copy.
- Driver's License will be copied upon check-in, for verifications reasons.
- The services we are seeing you for is cosmetic in nature. Payment for services will be expected the day of your appointment. We accept cash, check, MasterCard, Visa, Discover, American Express and Care Credit.

We are an on-time office and strive to respect our patient's valuable time. If you are going to be more than 10 minutes late for your appointment, please contact the office and we may have to reschedule you.

Please plan to arrive 15 minutes prior to your scheduled appointment time for check in. If you cancel less than 2-businees days in advance, you will be charged a $50 Cancellation fee and we will be unable to reschedule your appointment until that is paid. Please do not hesitate to call the office if you have any questions.

Sincerely,

Evexias Medical Center Staff

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:_____

EVEXIAS MEDICAL CENTERS

401 W Hampden Place, Suite 250
Englewood, CO 80110
(303) 777-VEIN (8346)
Fax: (303) 777-8377
www.denvervein.com

Patient Name: _____ DOB: _____

Medical History

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
❑	❑	Do you take oral anti-coagulant (blood thinning) medication? _____
❑	❑	Are you pregnant or trying to become pregnant?
❑	❑	Do you use oral contraceptives?
❑	❑	Do you use hormone replacement therapy?
❑	❑	Do you have any tattoos or permanent makeup?

SOCIAL HISTORY

Do you smoke? ☐ Current Everyday ☐ Current Some Day ☐ Never ☐ Former, when did you quit? _____
Do you use Tobacco? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes (If yes, how many drinks per day?) _____

List all Current Medical Problems

1. _____
2. _____

List all Surgeries and dates

1. _____
2. _____

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_____
3. Do you use any of the following Herbal Medications (check all the apply) ❑ Fish Oil ❑ St John's Wart ❑ Vitamin E

Allergies Are you allergic to any medicines, tape, Latex etc? _____

Which of these concerns you the most (check all that apply)

❑ Sun Damage	❑ Brown spots (Hyperpigmentation)	❑ Uneven skin tone
❑ Enlarged pores	❑ Visible exposed blood vessels	❑ Acne
❑ Upper lip lines	❑ Wrinkles	❑ Scarring
❑ Sun Spots	❑ Dry patches	❑ Unwanted Hair
❑ Clogged pores	❑ Other: _____	

What is your skin type: ❑ Dry ❑ Combination ❑ Oily ❑ Normal What skin care products are you using:_____

Have you ever had any of the following? ❑Yes (please indicate below) ❑ No
❑ Fillers ❑ Botox ❑ Implants

Do you have any of the following health problems or chronic skin disorders, past or present? Seizures ❑ Skin cancer ❑ Collagen (Lupus, Sarcoid, Scleroderma) ❑ Psoriasis ❑ Dermatitis ❑ Eczema ❑ Keloid Scarring ❑ Cold Sores/Fever Blisters ❑ Herpes Simplex/Blisters

Have you ever undergone any of the following treatments? ❑ Microdermabrasion ❑ Acid Peel ❑ Cosmetic Surgery ❑ Accutane

Are you currently removing hair by any of the following methods? ❑ Waxing ❑ Tweezing ❑ "Nair" type products ❑ Electrolysis ❑ Laser H Removal ❑ Shaving

Patient Signature_____ Date:_____

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

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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_____