PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US?

☐ Friend (Name:_____) ☐ Physician (Name:_____)
☐ Social Media ☐ Facebook ☐ Instagram ☐ RealSelf ☐ Nextdoor
☐ Internet - Google (Keyword Searched:_____) ☐ Other:_____

SERVICES YOU WOULD LIKE TO BE EVALUATED FOR: PROCEDURES/PRODUCTS OF INTEREST:

☐ Varicose Veins ☐ Spider Veins (please check one: ☐ Legs ☐ Face ☐ Hands ☐ Chest) ☐ Hormone Therapy
☐ Botox/Xeomin ☐ Dermal Fillers ☐ CoolSculpting ☐ MicroNeedling (SkinPen) ☐ Facial Rejuvenation
☐ Laser Hair Removal ☐ Medical SkinCare (SkinBetter Science/Obagi)

DEMOGRAPHICS:

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

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

Sex: ☐ M ☐ F **Marital Status:** ☐ S ☐ M ☐ W ☐ D **Date of Birth:** _____/_____/_____ **Age:**_____

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

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

Email:_____

Patient's Employer: _____ **Patient's Occupation:**_____

May we share your clinical information with your Primary Care Provider? ☐ **Yes** ☐ **No**

Primary Care Physician's Name: _____ **Phone:** _____

Preferred Pharmacy Name: _____ **Phone:** _____

EMERGENCY CONTACT:

Name:_____ Phone:_____ Relationship to Patient:_____

X_____(Signed) Date:_____

Denise C. Norton, MD ♦ Kelly Korte, NP-C ♦ Kaylin Brown, NP-C
401 W. Hampden Place, Suite 250 Englewood, CO 80110 (303) 777-8346

EVEXIAS MEDICAL CENTERS

Female BHRT Medical History

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

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Medical History

Have you?	No	Yes
Medical/GYN exam in last 12 mos?	☐	☐
Mammogram in last 12 mos?	☐	☐
Bone Density Scan in last 12 mos?	☐	☐
Pelvic Ultrasound in last 12 mos?	☐	☐

Are you pregnant or nursing? ☐ No ☐ Yes
How many pregnancies have you had? _____
Are you taking hormone replacement? ☐ No ☐ Yes Type:_____

Are you on birth control? ☐ No ☐ Yes
Type: ☐ Hysterectomy (Partial or Full) ☐ Menopause ☐ Tubal Ligation ☐ Birth Control Pills ☐ Vasectomy
☐ Regular Periods ☐ Irregular periods Last Menstrual Period or date of Menopause:_____

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?) _____

FAMILY HISTORY

Do you have a family history of Fibrocystic Breast Disease? ☐ Mother ☐ Sister ☐ Grandparent
Do you have a history of Breast Cancer in your family? ☐ Mother ☐ Sister ☐ Grandparent
Do you have a family history of Other Cancer? Type:_____ ☐ Father ☐ Mother ☐ Brother ☐ Sister

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_____

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

YOUR MEDICAL HISTORY Do you have any of the following problems? Please provide details.

CANCER

Have you ever been diagnosed with cancer? ☐ No ☐ Yes
Type: _____
Treatment: _____

COMMUNICABLE DISEASES

AIDS / HIV	☐ No	☐ Yes	_____
Hepatitis A / B / C	☐ No	☐ Yes	_____
STD	☐ No	☐ Yes	_____
Tuberculosis/Malaria	☐ No	☐ Yes	_____

MEDICAL ILLNESSES

High Blood Pressure	☐ No	☐ Yes	_____
Heart Bypass	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
Hypertension	☐ No	☐ Yes	_____
High Cholesterol	☐ No	☐ Yes	_____

MEDICAL ILLNESSES CONT

Stroke and/or Heart Attack	☐ No	☐ Yes	_____
Osteoporosis	☐ No	☐ Yes	_____
Clotting Disorder	☐ No	☐ Yes	_____
Blood clot (pulmonary emboli)	☐ No	☐ Yes	_____
Arrhythmia	☐ No	☐ Yes	_____
Lupus or other auto immune	☐ No	☐ Yes	_____
Fibromyalgia	☐ No	☐ Yes	_____
Trouble passing Urine	☐ No	☐ Yes	_____
Chronic Liver Disease	☐ No	☐ Yes	_____
Thyroid Disease	☐ No	☐ Yes	_____
Arthritis	☐ No	☐ Yes	_____
Depression/Anxiety	☐ No	☐ Yes	_____
Psychiatric Disorder	☐ No	☐ Yes	_____
Migraines	☐ No	☐ Yes	_____

Patient Signature:_____ Date:_____

EvexiPEL®

MRS Checklist - BEFORE HRT

Name:_____ **DOB:**_____ **Age:** _____ **Date:**_____

Which of the following symptoms apply at this time?
Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Hot flashes**	☐	☐	☐	☐	☐
2. **Night Sweats** (episodes of sweating)	☐	☐	☐	☐	☐
3. **Vaginal Dryness** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
4. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
5. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
6. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
7. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
8. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
9. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
10. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
11. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
12. **Joint & muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐
13. **Difficulty losing weight despite diet and/or exercise**	☐	☐	☐	☐	☐
14. **Feeling Cold**	☐	☐	☐	☐	☐
15. **Activity Level** (important to determine absorption rate)	☐ High	☐ Moderate	☐ Low		

Please share any additional comments about your symptoms you would like to address.

_____

_____

EVEXIAS MEDICAL DENVER • 401 W. HAMPDEN PLACE, SUITE 250 • ENGLEWOOD, CO 80110 • 720-625-8043• 303-777-8377
• www.evexiasmedicaldenver.com•

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WHAT MIGHT OCCUR (FOR FEMALES ONLY)

Patient Name:_____**DOB:**_____

A significant hormonal transition will occur in the first 3-6 weeks after beginning your BHRT regime. Therefore, certain changes might develop that can be bothersome.

FLUID RETENTION: Testosterone stimulates the muscle to grow and retain water, which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

SWELLING OF THE HANDS & FEET: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

UTERINE SPOTTING/BLEEDING: This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

MOOD SWINGS/IRRITABILITY: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system.

FACIAL BREAKOUT: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

HAIR THINNING: Is VERY rare and usually occurs in patients who over-convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in these rare cases.

HAIR GROWTH: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

I acknowledge that I have received a copy and understand the instructions on this form.

_____	_____	_____
Name (Print Legibly)	**Signature**	**Date**

401 W. Hampden Place, Suite 250
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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_____

STATEMENT OF FINANCIAL RESPONSIBILITY

Evexias Medical Denver appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. We expect these payments at time of service. I agree to pay Evexias Medical Denver, the full and entire amount of treatment given to me or to the above named patient at each visit.

We only accept insurance as a form of payment for lab work. You have the choice to file with your insurance or pay our cost. If you choose to file with your insurance for lab work instead of paying our cost you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. I understand and take full responsibility for any amounts not covered by my insurance provider.

We provide paperwork for BHRT services that you can use to submit to your insurance company for reimbursement. We are unable to assist with any additional paperwork or requests made by patients or insurance providers.

I understand that refunds or credits are not permitted on any prescriptive medication.

Cancellation / No Show Policy

- We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, in the case of regular scheduling conflicts, we ask you to call at least 2-business days' prior to cancel your appointment. 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.
- I understand in a given 12-month period, if I miss three or more scheduled appointments, or cancel three or more scheduled appointments with less than 2-business days' notice, I may be dismissed as a patient from Evexias Medical Center.

I have read the above policy regarding cancellation/no show policy and my financial responsibility to Evexias Medical Denver for providing any and all services to me, or the below named patient, and agree to be bound by its terms.

Patient Name (Print)	Patient Signature	Date
Guarantor Name *(required for patients < 18 years)*	Guarantor Signature	Date

EVEXIAS
MEDICAL CENTERS

Fee Acknowledgment

Although more insurance companies are reimbursing patients for Bio-Identical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your BHRT visit and procedure (see fee schedule below).

Office Visits	
New Patient Consultation Fee	$150
5-week Initial Follow up after 1st pellet insert	No Charge
Follow up Provider Visits (determined at appt)	$75-$150-$225
Labs	
Full Panel Lab Fee – Initial Visit/Annual	$250
Post-Procedure follow up Lab	$125
Thyroid Only Lab Fee	$50
Pellets	
Female Hormone Pellet Insertion Fee	$330
Male Hormone Pellet Insertion Fee	$625
Male Hormone Pellet Insertion Fee (> 2000mg)	$725

Upon request, we will give you the appropriate paperwork so you can file for reimbursement with your health insurance company.

Print Name _____ Signature _____ Date _____

We accept the following forms of payment

*American Express, Master Card, Visa, Discover, Checks, Cash and Care Credit**