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

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

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

MEDICAL HISTORY

Have you had a Urological work-up in last 12 mos? ☐ No ☐ Yes
Recent Digital Rectal Exam (Date): _____ Normal / Abnormal
History of Prostate problems or Biopsy. If so, please provide details. _____
Previous HRT Therapy? ☐ No ☐ Yes, Type: _____
Currently on HRT Therapy ☐ No ☐ Yes, Type: _____
Vasectomy? ☐ No ☐ Yes

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 Heart Disease?	☐ Parent ☐ Sibling ☐ Grandparent
Do you have a family history of Stroke?	☐ Parent ☐ Sibling ☐ Grandparent
Do you have a family history of High Blood Pressure?	☐ Parent ☐ Sibling ☐ Grandparent
Do you have a family history of Prostate or Testicular Cancer?	☐ Father ☐ Grandfather
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: _____
Year: _____

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	_____
Stroke and/or Heart Attack	☐ No ☐ Yes	_____
Clotting Disorder	☐ No ☐ Yes	_____

MEDICAL ILLNESSES CONT.

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	_____
Trouble passing urine or take Flomax or Avodart?	☐ No ☐ Yes	_____
Prostate enlargement?	☐ No ☐ Yes	_____
Elevated PSA?	☐ No ☐ Yes	_____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, I will produce less testosterone from my testicles. And if I stop testosterone replacement, I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of my system in 12 months.

Patient Signature:_____ Date:_____

EvexiPEL®

AMS 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. **Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. **Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. **Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6. **Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. **Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. **Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9. **Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. **Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13. **Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14. **Decrease in beard growth**	☐	☐	☐	☐	☐
15. **Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16. **Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17. **Decrease in sexual desire/libido** (lacking pleasure in sex, lack of desire)	☐	☐	☐	☐	☐
18. **Activity Level** (High, Med High, Med Low, Low)	H☐	MH☐	ML☐	L☐	

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

_____

_____

_____

_____

_____

_____

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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**