Denise C. Norton, M.D.
Kelly Korte, NP-C
Denver Vein Center/Evexias Denver
401 W Hampden Place, Suite 250
Englewood, CO 80110
(303) 777-VEIN (8346)
Fax: (303) 777-8377

www.denvervein.com
www.evexiasdenver.com

WELCOME TO OUR PRACTICE! We are looking forward to meeting you and partnering with you on your journey toward optimal health and wellness!

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

- Every patient will be expected to complete our Patient Information, Patient Medical History, Hormone Checklist, Financial & 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.

- Current Insurance card (if applicable) and Driver's License will be copied upon check-in, for verifications reasons.

- You will need to provide a credit card on file. Your card information will be securely protected by the credit-card processing component of our HIPAA-compliant practice management system. Once entered, staff cannot access the entire card number and will only see the last 4 digits.

- Insurance will be billed for new consultations and office visits. Co-payments are required at time of appointment. We will bill your insurance and you will be responsible for any additional co-insurance or deductible fees as determined by your insurance plan. We accept cash, check, MasterCard, Visa, Discover and American Express.

We participate with many insurance companies; please see our website for a complete listing. If you have a question about your insurance, please call our office ahead of your scheduled appointment.

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,

Denver Vein/Evexias Medical Center Staff

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 ☐ Other **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
401 W. Hampden Place, Suite 250 Englewood, CO 80110 (303) 777-8346

Credit Card on File Policy

We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. With the changing environment in healthcare, insurance policies have transferred more responsibility of payment on the patient in the form of co-payments and deductibles. Thus, it has become necessary to ensure we have a guarantee of payment on file for the services rendered.

Effective August 31, 2021, we will be requiring all patients to keep a credit card on file. We will collect your credit card information at the time of your first visit. Your card information is securely protected by the credit-card processing component of our HIPAA-compliant practice management system. Once entered, staff cannot access the entire card number – we only can see the last 4 digits.

Circumstances when your card would be charged include:

- Missed or canceled appointments without 48-hour notice
- Missed co-payments, deductible, and co-insurance
- Any non-covered services and/or denial of services allocated to patient responsibility
- Outstanding balance greater than 90 days past due (unless a payment plan has been arranged)
- Purchases of product or prescriptions as requested by you (the patient)

Please note, the billing process is still the same. Your insurance will be billed, they pay their portion and notify us of the balance due (if any). Once we are notified, you will be sent a statement. Your credit card will only be charged for any outstanding balance 90 days after the first statement is sent. If you cannot pay the balance in full, please contact us to make payment arrangements. If we do not hear from you, then we will charge your card at the 90 day mark. Balances on accounts must be paid, or payment arrangements must be made prior to making further appointments.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. We will continue to work with you to resolve all charges.

If you have any questions, please do not hesitate to ask.

Thank you,

Your Denver Vein/Evexias Medical Team

Denver Vein Center | Evexias Medical Center
401 W. Hampden Place, Suite 250 · Englewood, CO 80110
Phone 303.777.8346 (VEIN) · Fax 303.777.8377 · DenverVein.com
Denise C. Norton, MD., FACS, RVT

FINANCIAL & CANCELLATION POLICY

Thank you for choosing Denver Vein Center/Evexias Medical Center for your healthcare needs. In order to achieve our goal of providing and maintaining a good practitioner-patient relationship, and providing our patients with high quality, cost-effective care, we need to have a solid financial policy. We strive to render care in a timely and prompt manner. 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 please call if you are running late. We ask that you carefully read and sign the following policy prior to your treatment.

We require all patients to keep a credit card on file. We will collect one at the time of your first visit. Your card information is securely protected by the credit-card processing component of our HIPAA-compliant practice management system. Once entered, we cannot access the entire card number – we only can see the last 4 digits.

Circumstances when your card would be charged include:

- Missed or canceled appointments without 48-hour notice
- Missed co-payments, deductible and co-insurance
- Any non-covered services and/or denial of services allocated to patient responsibility.
- Outstanding balance greater than 90 days past due (unless a payment plan has been arranged)
- Purchases of product or prescriptions as requested by you (the patient)

- We require 48-hour notice for cancelling any appointments. A **$50 cancellation fee** will be assessed and must be paid prior to rescheduling your appointment.
- A **$200 cancellation fee** will be charged for all Endovenous Laser Ablations, Phlebectomy and Ligation surgeries cancelled with less than 2 weeks notice. This is due to time constraints in getting prior authorization.
- Upon arrival, please present your current health insurance card as well as your driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our practitioners do not participate in your health insurance plan, payment IN FULL is due at the time of service. Acceptable forms of payment are cash, check, VISA, MasterCard, Discover, American Express and Care Credit.
- You are responsible to make complete insurance information available to Denver Vein Center/Evexias Medical Center for accurate filing of claims. If the insurance information that you provide at the time of your visit is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that you may owe at the time of service.
- Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility. **It is your responsibility to know your healthcare benefits and coverage limitations.**
- For scheduled appointments, prior balances must be paid prior to the visit.
- A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A $35 fee is required for the completion of forms regarding disability insurance, life insurance and FMLA.

I have read and understand Denver Vein Center/Evexias Medical Center and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy.

_____

Patient's Printed Name

_____ _____

Patient Signature Date

Denise Norton, MD • Kelly Korte, NP-C
401 W. Hampden Place, Suite 250
Englewood, CO 80110
(303)777-8346 or (720)625-8043

EVEXIAS MEDICAL CENTERS
Denver Vein Center

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: _____
Have you been diagnosed with PCOS? ☐ No ☐ Yes

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: _____

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: _____

EVEXIAS MEDICAL CENTERS
Denver Vein Center

Female BHRT Medical History Review of Systems

401 W Hampden Place, Suite 250
Englewood, CO 80110

Patient Name: _____ DOB: _____

YOUR MEDICAL HISTORY / REVIEW OF SYSTEMS

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

CONSTITUTIONAL
- Fever ☐ No ☐ Yes _____
- Chills ☐ No ☐ Yes _____
- Weight loss ☐ No ☐ Yes _____

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

HEAD, EYES, EARS, NOSE, THROAT
- Ear ☐ No ☐ Yes _____
- Eye ☐ No ☐ Yes _____
- Nose/Sinus ☐ No ☐ Yes _____
- Throat ☐ No ☐ Yes _____

RESPIRATORY
- Shortness of breath ☐ No ☐ Yes _____
- Chronic cough ☐ No ☐ Yes _____
- Emphysema/COPD ☐ No ☐ Yes _____
- Asthma ☐ No ☐ Yes _____
- Bronchitis ☐ No ☐ Yes _____
- Pneumonia ☐ No ☐ Yes _____
- Pulmonary embolism ☐ No ☐ Yes _____
- Sleep Apnea ☐ No ☐ Yes _____

CARDIOVASCULAR
- Heart murmur ☐ No ☐ Yes _____
- Chest pain ☐ No ☐ Yes _____
- Palpations/heart racing ☐ No ☐ Yes _____
- Congestive heart failure ☐ No ☐ Yes _____
- Heart attack ☐ No ☐ Yes _____
- High blood pressure ☐ No ☐ Yes _____
- Pacemaker ☐ No ☐ Yes _____
- Artificial Heart Valve ☐ No ☐ Yes _____
- Cardiac Stent/Angioplasty ☐ No ☐ Yes _____

GASTROINTESTINAL
- Abdominal pain ☐ No ☐ Yes _____
- Nausea / Vomiting ☐ No ☐ Yes _____
- Constipation/Diarrhea ☐ No ☐ Yes _____
- Colitis ☐ No ☐ Yes _____
- Diverticulitis ☐ No ☐ Yes _____
- Hiatal Hernia ☐ No ☐ Yes _____
- Reflux Esophagitis ☐ No ☐ Yes _____

GASTROINTESTINAL (CONT)
- Irritable bowel ☐ No ☐ Yes _____
- Ulcers ☐ No ☐ Yes _____
- Pancreatitis ☐ No ☐ Yes _____
- Cirrhosis/Jaundice ☐ No ☐ Yes _____
- Gallstones ☐ No ☐ Yes _____
- Hemorrhoids ☐ No ☐ Yes _____

GENITOURINARY / GYN
- Prostate ☐ No ☐ Yes _____
- Uterine ☐ No ☐ Yes _____
- Ovarian ☐ No ☐ Yes _____
- Bladder infections ☐ No ☐ Yes _____
- Kidney ☐ No ☐ Yes _____

MUSCULOSKELETAL / SKIN
- Back/Neck/Joint issues ☐ No ☐ Yes _____
- Rash/Skin breakdown ☐ No ☐ Yes _____
- Arthritis (type) ☐ No ☐ Yes _____
- Fractures ☐ No ☐ Yes _____
- Osteoporosis ☐ No ☐ Yes _____

NEUROLOGICAL
- Numbness/tingling ☐ No ☐ Yes _____
- Loss of strength ☐ No ☐ Yes _____
- Stroke (CVA/TIA) ☐ No ☐ Yes _____
- Headaches (type) ☐ No ☐ Yes _____
- MS ☐ No ☐ Yes _____

ENDOCRINE
- Excessive thirst ☐ No ☐ Yes _____
- Diabetes ☐ No ☐ Yes _____
- Thyroid ☐ No ☐ Yes _____
- Parathyroid ☐ No ☐ Yes _____

HEMATOLOGIC
- Swollen lymph glands ☐ No ☐ Yes _____
- Anemia ☐ No ☐ Yes _____
- Lupus ☐ No ☐ Yes _____

PSYCHIATRIC (MENTAL STATUS/EMOTIONAL)
- Nervousness ☐ No ☐ Yes _____
- Depression ☐ No ☐ Yes _____
- Other (describe) ☐ No ☐ Yes _____

Patient Signature _____ Date: _____

EVEXIAS MEDICAL CENTERS | Denver Vein Center

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

Patient Name:_____ **DOB:**_____ **AGE:**_____ **Date:**_____

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

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

_____

_____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?

_____

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**

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/or procedure (see fee schedule below). If you choose to go through insurance for your labs and office visits, we will bill those directly to your insurance and you will be responsible for your co-pay at the time of service. Once we bill your insurance, we are unable to offer the cash discount.

LABS	INSURANCE FEE	CASH FEE
Full Lab Panel (Initial Visit/Annual)	Billed through LabCorp	$250
Post-procedure follow up labs	Billed through LabCorp	$125
Thyroid Lab Panel	Billed through LabCorp	Basic Panel - $50 Full Panel - $100
Other Labs	Billed through LabCorp	TBD as needed
OFFICE VISITS	**INSURANCE FEE**	**CASH FEE**
New Patient Consult	TBD by insurance carrier, Copay Due	$150
Office Visits (follow up appointments, procedure appointments, lab reviews)	TBD by insurance carrier, Copay Due	$75-$225 (BASED ON TIME)
MEDICAL MANAGEMENT VISITS	**INSURANCE FEE**	**CASH FEE**
Office Visit for medical management (non-pellet patients, getting oral or creams)	TBD by insurance carrier, Copay Due	$75-$225 (BASED ON TIME)
PELLET INSERTION	**INSURANCE FEE**	**CASH FEE**
Female Hormone Pellet Insertion	NOT APPLICABLE (invoice provided for patient to bill independently)	$330
Male Hormone Pellet Insertion Fee	NOT APPLICABLE (invoice provided for patient to bill independently)	$625
Male Hormone Pellet Insertion Fee (>2000mg)	NOT APPLICABLE (invoice provided for patient to bill independently)	$725

Print Name _____ Signature _____ Date _____

We accept the following forms of payment

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

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(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_____