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

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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_____

MEDICAL HISTORY COSMETIC
401 W Hampden Place, Suite 250
Englewood, CO 80110
Phone: (720)625-8043
Text: (720)731-0359
Fax: (303) 777-8377
www.evexiasdenver.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?

☐ HIV/Aids ☐ Hepatitis A/B/C ☐ Other: _____

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:_____