



Denver Vein Center/Evexias Denver
2696 S. Colorado Blvd., Suite 110
Denver, CO 80222
(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 Acknowledgement forms. Copies of the complete HIPAA Privacy Practices are available online or in the office, please let the front desk know if you would like a copy.
- We give patients the option to bill Insurance 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. Please indicate on the fee acknowledgement form if you want to use Cash or Insurance for your visit.
- 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.

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. If we are out of network, you will need to elect "cash" for your consultation and office visit.

Please plan to arrive 15 minutes prior to your scheduled appointment time for check in. If you cancel less than 2-business 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.

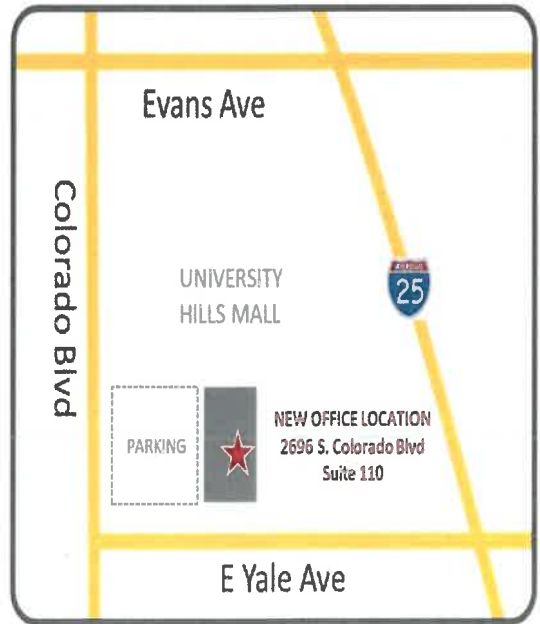
Sincerely,

Denver Vein/Evexias Medical Center Staff



WE HAVE MOVED!

Our new address is 2696 S. Colorado Blvd, Suite 110





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: _____



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

MEDICAL HISTORY

Reason for Visit: _____ How long has it been present? _____

VEIN ISSUES - Indicate yes with Check Mark (✓)

Symptom	Right	Left
Pain		
Itching		
Heaviness		
Aching		
Swelling/Edema		

Symptom	Right	Left
Spontaneous Bleeding		
Thrombosis (Blood Clot/DVT)		
Ulceration		
Cramping/Restless Leg		
Other:		

Have you had Previous treatments for varicose veins? No Yes If yes, Type: _____
 Have you used conservative measures (list all that apply) Compression Stockings Leg Elevations NSAIDS Exercise

For Females Only:

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? N Y
 Type of Birth Control: Hysterectomy Menopause Tubal Ligation Vasectomy Birth Control Pills
 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 history of Varicose Veins in your family? Father Mother Brother Sister Grandparent
 Do you have a history of Hypertension in your family? Father Mother Brother Sister
 Do you have a history of Cancer in your family? Type: _____ Father Mother Brother Sister
 Do you have History of Bleeding Problems in your family? Father Mother Brother Sister
 Do you have a history of Heart Attack in your family? Father Mother Brother Sister
 Do you have a history of Diabetes in your family? Father Mother Brother Sister
 Do you have a history of Hyperlipidemia in your family? Father Mother Brother Sister
 Do you have a history of Asthma in your family? Father Mother Brother Sister

List all Current Medical Problems

- _____
- _____
- _____

List all Surgeries and dates

- _____
- _____
- _____

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. _____ | Dose _____ | Reason _____ |

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

Patient Signature _____ Date: _____

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 _____

CANCER

Have you ever been diagnosed with cancer? No Yes

Type: _____
 Treatment: _____
 Location: _____

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 _____
- Palpitations/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 _____
- 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 _____

HORMONAL (WOMEN)

- Hot Flashes No Yes _____
- Night Sweats No Yes _____
- Vaginal Dryness No Yes _____

HORMONAL (MEN & WOMEN)

- Sleep Problems No Yes _____
- Sexual Problems/Low Libido No Yes _____
- Difficulty Losing Weight No Yes _____
- Feeling Cold No Yes _____
- Physical/Mental Exhaustion No Yes _____
- Decline in overall well-being No Yes _____
- Decrease in muscular strength No Yes _____

Patient Signature _____

Date: _____



BILL INSURANCE CONSENT

Please read carefully before signing

I acknowledge I have been offered cash pricing and have elected to bill my insurance for my office visits. I have provided a copy of my insurance card for these purposes.

1. I understand that the practitioner will use appropriate CPT codes recognized by my insurance company.
2. I understand that the amount billed to my insurance is based on the CPT code. These fees can range from \$200-\$400 depending on the type of visit.
3. I understand that Evexias/Denver Vein has a contract with my insurance company and will take the appropriate contractual write off.
4. I understand I am responsible for my insurance benefits and I will be accountable for all balances due after my insurance has paid, including co-pay, co-insurance or deductible.
5. I understand that the amount paid (allowed) is determined by my insurance company, not my provider.
6. I understand once insurance has processed the claim, I am no longer able to take advantage of the cash pricing (the only exception is if insurance fully denies the claim).

I hereby assign my right and authorize payment of medical benefits to Evexias Medical/Denver Vein Center for these services and authorize the release of any medical information necessary to process this claim.

Print Name

Patient Signature

Date



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



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



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 Denver, CO 80222
 (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** _____