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-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,

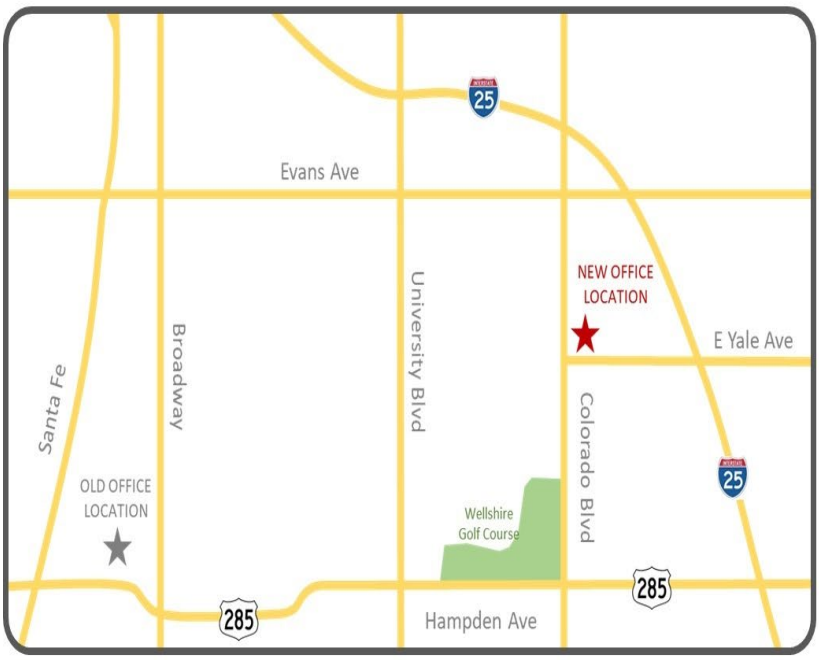
Denver Vein/Evexias Medical Center Staff

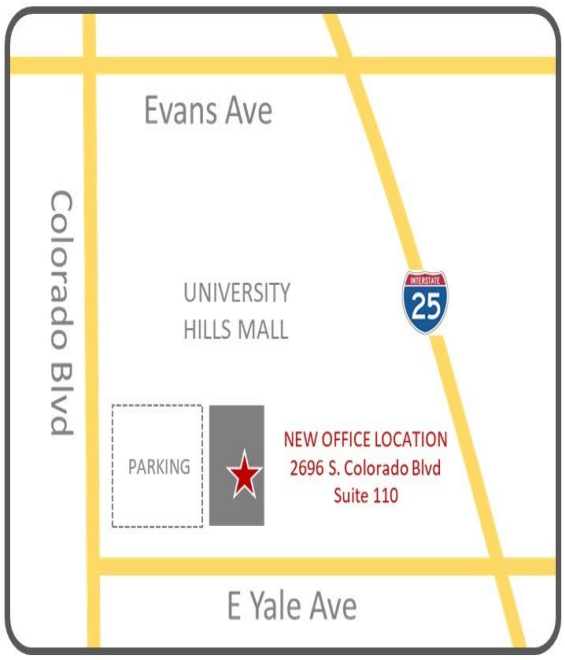
Denver Vein Center

EVEXIAS MEDICAL CENTERS

WE HAVE MOVED!

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





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

Denver Vein Center • Evexias Medical Denver
2696 S. Colorado Blvd., Suite 110
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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_____

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:_____

Evexias Medical Denver
2696 S. Colorado Blvd., Suite 110, Denver, CO 80222
(303) 777-8346

Male BHRT Medical History

2696 S. Colorado Blvd., Suite 110
Denver, CO 80222
(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
☐ HIV/Aids ☐ Hepatitis A/B/C ☐ Erectile Dysfunction ☐ Other: _____

List all Current Medical Problems

1. _____
2. _____
3. _____

List all Surgeries and dates

1. _____
2. _____
3. _____

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? _____

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

MEDICAL ILLNESSES

High Blood Pressure	☐ No ☐ Yes _____	Trouble passing Urine	☐ No ☐ Yes _____
Heart Bypass	☐ No ☐ Yes _____	Chronic Liver Disease	☐ No ☐ Yes _____
Heart Disease	☐ No ☐ Yes _____	Thyroid Disease	☐ No ☐ Yes _____
Hypertension	☐ No ☐ Yes _____	Arthritis	☐ No ☐ Yes _____
High Cholesterol	☐ No ☐ Yes _____	Depression/Anxiety	☐ No ☐ Yes _____
Stroke and/or Heart Attack	☐ No ☐ Yes _____	Psychiatric Disorder	☐ No ☐ Yes_____
Clotting Disorder	☐ No ☐ Yes _____	Migraines	☐ No ☐ Yes _____
Blood clot (pulmonary emboli)	☐ No ☐ Yes _____	Trouble passing urine or take Flomax or Avodart?	☐ No ☐ Yes _____
Arrhythmia	☐ No ☐ Yes _____	Prostate enlargement?	☐ No ☐ Yes _____
Lupus or other auto immune	☐ No ☐ Yes _____	Elevated PSA?	☐ No ☐ Yes _____
Fibromyalgia	☐ No ☐ Yes _____		

CANCER

Have you ever been diagnosed with cancer? ☐ No ☐ Yes

Type: _____
Treatment: _____
Year: _____

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

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:_____

Male BHRT Medical History
Review of Systems

2696 S. Colorado Blvd., Suite 110
Denver, CO 80222

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	_____
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:_____

AMS 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. 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, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

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)

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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. Billing your insurance will not guarantee there is no cost to you, you may be responsible for any co-insurance or deductible you might have. It is your responsibility to know your healthcare benefits and coverage. Once we bill your insurance, we are unable to offer the cash discount. Please select Cash or Insurance below.

LABS	**INSURANCE FEE** ☐ **PLEASE BILL INSURANCE**	**CASH FEE** ☐
Full Lab Panel (Initial Visit/Annual)	Billed through LabCorp	$285
Post-procedure follow up labs	Billed through LabCorp	$135
Thyroid Lab Panel	Billed through LabCorp	Basic Panel - $65 Full Panel - $115
Other Labs	Billed through LabCorp	TBD as needed
OFFICE VISITS	**INSURANCE FEE** ☐ **PLEASE BILL INSURANCE**	**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** ☐ **PLEASE BILL INSURANCE**	**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 - NOT APPLICABLE**	**CASH FEE**
Female Hormone Pellet Insertion	NOT APPLICABLE (invoice provided for patient to bill independently)	$350
Male Hormone Pellet Insertion Fee	NOT APPLICABLE (invoice provided for patient to bill independently)	$750

Print Name _____ Signature _____ Date _____

We accept the following forms of payment

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

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 $100-$300 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