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, 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 ultrasounds. 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.

If you are a cash pay patient, fees for services will be discussed at your consultation.

Dr. Norton participates 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.

Dr. Norton makes every effort to run on time and the expectation is to have you back in a room within 5 minutes of your appointment time. If you are going to be more than 10 minutes late for your appointment, please contact the office and we may have to reschedule you.

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,

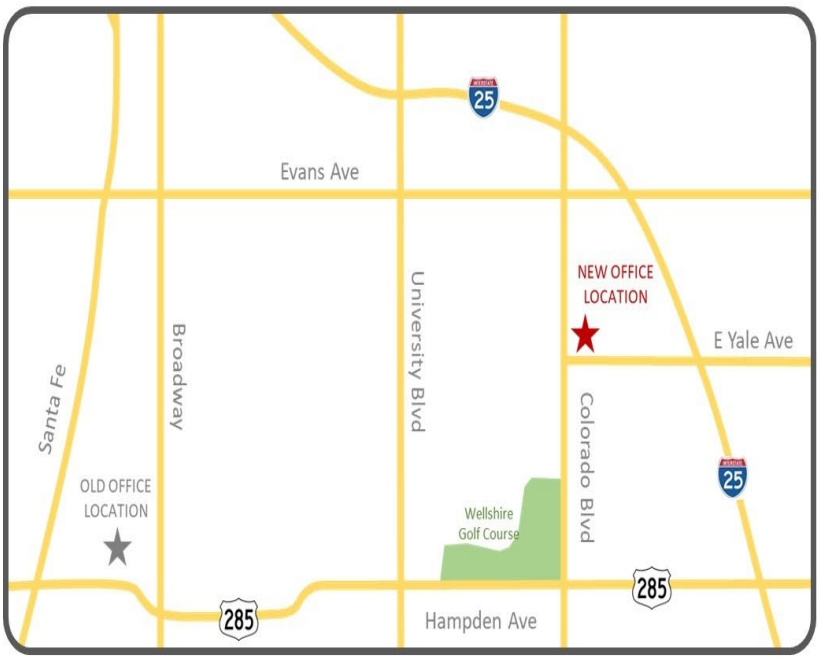
Denver Vein/Evexias Medical Center Staff

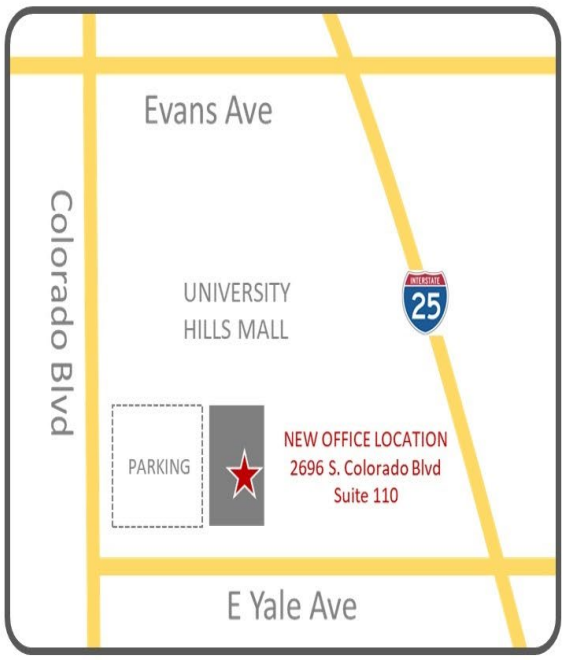
Denver Vein Center

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

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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:_____

INSURANCE INFORMATION

Insurance Name: _____ Name of Insured:_____ DOB:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

I HEREBY ASSIGN MY RIGHT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DENVER VEIN CLINIC AND/OR EVEXIAS MEDICAL CENTER FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X_____(Signed) Date:_____

Varicose Vein Medical History
Denver Vein Center
2696 S. Colorado Blvd., Suite 110
Denver, CO 80222

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

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_____
3. _____ Dose_____ Reason_____

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

Patient Signature_____Date:_____
Patient Name: _____ DOB: _____

Varicose Vein Medical History
Denver Vein Center
2696 S. Colorado Blvd., Suite 110
Denver, CO 80222

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	_____
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:_____

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ULTRASOUND CONSENT

Please read carefully before signing

I hereby give my consent for Denise Norton, MD, RVT, RPVI to perform a Duplex Ultrasound study on my ☐ Right ☐ Left leg. Dr. Norton is a trained Registered Vascular Technologist and Registered Physician in Vascular Interpretation and is qualified to perform this service.

1. This ultrasound is being performed for diagnostic purposes and is required by your insurance company to determine medical necessity. Without this procedure, we will be unable to submit to your insurance for prior authorization should you require treatment.
2. All insurance companies require the diameter of the veins be measured as well as recording reflux in the veins.
3. You will be charged for this ultrasound even if your measurements do not meet criteria and it is deemed cosmetic by your insurance company.
4. Each insurance company has their own requirements as to what they deem medically necessary and this is not determined by this office.
5. Our office does not determine the cost of the ultrasound. The cost is determined by your insurance company and not every insurance is the same.

Patient Consent: I have read and fully understand this consent form. I understand that I should not sign this form unless all of my questions have been answered and explained to my satisfaction. I have no further questions. I authorize Dr. Norton to bill my insurance for these services and understand that I am responsible for all charges, including co-pay, co-insurance or deductible. Any balance after insurance has paid is due by me. I understand that my insurance benefits and referral requirements are my responsibility.

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

_____ _____
Print Name Patient Signature

_____
Date