Peter B. Morgan, M.D.
Specializing in the Treatment of Venous Disease

PLEASE FILL IN ALL THE BLANKS

Patient Demographic Sheet

Date: ______________________

Last Name: ______________________ First Name: ______________________ MI: ____

Age: ____ Birthdate: ______________ SS#: ______________ Marital Status ____ Race: ____

Address: ______________________ Email: ______________________

City: ______________________ State: ________ ZIP: ______________

Home#: ______________ Cell#: ______________ Work#: ______________

Emergency Contact: ______________ Relative: ________ Phone: ______________

I AGREE TO BE CONTACTED AT THE NUMBERS ABOVE FOR EMERGENCY REASONS INCLUDING THE POSSIBILITY OF MOVING OR CONFIRMING MY APPOINTMENT(S). ____________ Initials

Employer: ______________________

Employer Address: ______________________ City: ______________

State: ________ Zip: ________ Phone: ________ Fax: ________

INSURANCE COMPANY: ______________________ Phone#: ______________

Policy Holder's Name: ______________ DOB: ________ SS#: ________

Policy Holder's Employer: ______________ Id/Policy: ________ Group: ________

Insurance Company Address: ______________________

Specialist office visit co-payment: $ ____________

SECONDARY INSURANCE COMPANY: ______________ Phone#: ______________

Policy Holder's Name: ______________ DOB: ________ SS#: ________

Policy Holder's Employer: ______________ Id/Policy: ________ Group: ________

Insurance Company Address: ______________________

Specialist office visit co-payment: $ ____________

Assignment and release

I hereby authorize my Health Insurance Company(s) to pay all benefits directly to Peter B. Morgan, M.D. for all services provided at Lone Star Vein Center. I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Payment is due at the time of service unless insurance is being billed.

Patient Signature: ______________________ Date: ______________

6243 Fairmont Parkway, Suite 200
Pasadena, Texas 77505
Office: 281-991-8346

9303 Pinecroft Drive, Suite 350
The Woodlands, Texas 77380
Office: 281-292-0121

www.LoneStarVeinCenter.com
drmorgan@lonestarveincenter.com
Fax: 866-722-4293

Peter B. Morgan, M.D.
Specialized Vein Care

I ______________________________ am the insured, have health insurance benefits with

______________________________ that are provided to me by employer that is engaged in commerce, as defined in 29 USC 18, S1003 (a), do hereby designate Peter B. Morgan and his business associate Diana Franklin, to be my authorized representative as defined in Federal Regulation 29 CFR 2560-503-1, to fully act on my behalf to submit my claim(s) for healthcare benefits payments, to obtain any and all information from my health insurer that will be used in an appeal of my adverse benefit determination, as defined in 29 CFR 2560-503-1, and to represent me in a Federal Court of law, to appeal any and all adverse benefit determinations and any and all actions to ensure that my employer provided health benefit payments are correctly paid according to contract. My Health Insurance is to provide Peter Morgan or Diana Franklin with any and all requests for the discovery of any and all documents used by my health insurance to deny my health benefit payment when not paid in full. If any outside policies or consultants were used to perform the adverse benefit determination my insurance is directed to provide my authorized representative with a legible copy of said policy, the name and specialty of the person who performed the adverse benefit determination, the name and credentials of any consultants, and any and all documents provided by said consultant. My authorized representative is authorized to file grievances with any and all applicable State or Federal regulatory agencies and to represent me in any legal action in a Federal Court of law. Copies of this authorization are to be treated as if it were the original document.

____

Patient signature and date

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Peter B. Morgan, M.D.
Specializing in the Treatment of Venous Disease

I, ____, have read and understand the HIPAA Notice of Privacy Practices of Dr. Peter B. Morgan's office.

_____ I want a copy of the HIPAA Privacy Policy

_____ I do not want a copy of the HIPAA Privacy Policy

****

I have given permission for the office of Dr. Peter B. Morgan to discuss my medical history/condition with the following person(s):

Name: ____

____

____

____

_____ I give permission for Dr. Peter B. Morgan to communicate with my Primary Care Physician regarding my medical treatment.

________________________________ Patient Signature

________________________________ Date

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PETER B. MORGAN, M.D.
BOARD CERTIFIED GENERAL SURGEON
SPECIALIZED VEIN CARE

LONE STAR VEIN CENTER OFFICE & FINANCIAL POLICIES

Insurance Guidelines-Please understand that Dr. Morgan is contracted by your insurance. Our office MUST follow your insurance guidelines. If your insurance requires a stocking trial, we will not start precertification until you have completed the stocking trial requirements.

Copay/financial responsibility- Please be advised that anytime you have an office visit, ultrasound, or any type of treatment, you will be responsible for any copays or patient responsibilities. If you come in for an ultrasound and do not wish to wait for results, we will be more than happy to schedule you a follow up and we will collect your copay on your next visit.

Schedule-Please note, we try to stay on schedule, but Dr. Morgan pays attention to every patient's needs, therefore, sometimes we may be off schedule.We apologize in advance.

Cancellation policy- We bare a minimum of 24 hour notice of a cancellation or rescheduling. We will collect the $45 fee before you are seen for your next visit. Any further offense is an indication that you do not regard ou time, energy, or needs of the other patients. The next time this occurs, it will result in the termination of the doctor-patient relationship due to non-compliance. Your cooperation is greatly appreciated.

Arrival time-Please be advised we ask all of our patients to arrive 15 minutes early for any ultrasound or procedure appointment. It can take up to 15 minutes to check in, EVEN if you are an established patient. If you are late for your appointment, (if you do not show up at the time we asked, 15 minutes early), you will have to schedule.

Photo Consent- I consent to still photography, video, and audio recordings for the purpose of scientific, educational, medical documentation and quality care. Recording, and or images will be treated the same as all medical records and privacy rules.________**Initials**

Spider veins- Spider veins are small/black veins seen on your legs. They are called spiders veins because they appear like spiders. These veins are always cosmetic. Insurance companies never pay for treatment of spider veins. Lone Star Vein Center is proud to feature the Cutera Excel V laser for cosmetic vein treatments. In some patients the spider veins may have little improvement after one treatment. It may take more than one session. The spider treatment session is twenty five minutes. The session is $375.00 and fee applies for each session. However, we de offer a discount of $50. 00 if paid in cash. We can treat spider veins at a later date, not the same as your procedure. If you come to see Dr. Morgan with the only issue being spider veins please make that very clear as we do not want you to think that treatment of chronic venous insufficiency will provide resolution of spider veins.

By signing below, I am acknowledging that I have read, understood, and have agreed to Lone Star Vein Center policies.

Patient Signature________________________________ **Date**________________

Lone Star Vein Center

Peter B. Morgan, M.D.

Patient Vein History Form

Name:			Date:	
DOB:	Sex:	[ ] M [ ] F	Insurance Provider:	
Age: Height: Weight:			Referring Physician:	
How Did you hear about us?				

I. Vascular History

Do you have or have you ever been diagnosed with:

Deep Vein Thrombosis (DVT) Blood Clots	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Varicose Veins	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Superficial Phlebitis (Vein Redness/Tenderness)	[ ] Y	[ ] N	Leg:	[ ] R [ ] L

Do you experience any of the following in your leg(s):

Aching/Pain	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Heaviness	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Tiredness/Fatigue	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Itching/Burning	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Swelling	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Cramps	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Restless Legs	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Throbbing	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Skin or Ulcer Problems	[ ] Y	[ ] N	Leg:	[ ] R [ ] L
Does prolonged sitting or standing aggravate your legs?	[ ] Y	[ ] N		
Are your veins getting worse?	[ ] Y	[ ] N		

How long have you had problems with your veins?

Which of the following do you currently do to improve your leg symptoms?

Medication for Pain	[ ] Y	[ ] N	What?
Wear Support Hose	[ ] Y	[ ] N	Date Started:
Elevation of Legs	[ ] Y	[ ] N	

Family History

Have any of your family members had:

Varicose Veins	[ ] Y	[ ] N	Who?
Vein Stripping	[ ] Y	[ ] N	Who?
Blood Coagulation Disorder	[ ] Y	[ ] N	Who?
Blood Clots	[ ] Y	[ ] N	Who?

Past Surgeries
1
2
3
4

Personal Activities List: Does your work or lifestyle require:

Prolonged Standing Periods	☐	Y	☐	N
Prolonged Sitting Periods	☐	Y	☐	N
Do you exercise regularly?	☐	Y	☐	N

Current Medication List, Dosage and Supplements

Medication MG	Route	Times per day

Allergies:

Additional Comments:

Have you had a pneumonia vaccine?	☐	**Yes**	☐	**No**
If yes, when?				
Do you have a living will?	☐	**Yes**	☐	**No**
If no, would you like a copy of one?				
Have you had any falls in the last year?	☐	**Yes**	☐	**No**

To be completed by all patients				
Have you had a flu shot?	☐	Yes	☐	No
When was your last flu shot?				

Lone Star Vein Center **Peter B. Morgan, M.D.**

<u>Your</u> personal past medical history, not your family, or anyone else, just <u>your own</u> past medical history					
Stroke	☐	Y	☐	N	
Heart Attack	☐	Y	☐	N	
Diabetes	☐	Y	☐	N	
High Blood Pressure	☐	Y	☐	N	
Kidney Disease	☐	Y	☐	N	
Liver Disease	☐	Y	☐	N	
Tobacco Use	☐	Y	☐	N	
Pregnancies	☐	Y	☐	N	
Cancer	☐	Y	☐	N	
Lupus	☐	Y	☐	N	
Heart Disease	☐	Y	☐	N	
STD	☐	Y	☐	N	
Are you Pregnant	☐	Y	☐	N	

Do you have any major illnesses not listed above?______________________________________

____

____

____

Signature: ____

Date: ____

0- C I V I Q -14 -
SELF-QUESTIONNAIRE PATIENTS

Circle the number that applies to you.

1) During the past four weeks, have you had any **pain** in your **ankles or legs**, and how severe has this pain been?

1	2	3	4	5
No pain	Slight pain	Moderate pain	Considerable pain	Severe pain

2) During the past four weeks, how much trouble have you had at **work** or with your **usual daily activities because of your leg problems?**

1	2	3	4	5
No trouble	Slight trouble	Moderate trouble	Considerable trouble	Severe trouble

3) During the past four weeks, have you **slept poorly** because of your leg problems, and how often?.

1	2	3	4	5
Never	Rarely	Fairly often	Very often	Every night

During the past four weeks, how much **trouble** have you had **carrying out the actions and activities listed below because of your leg problems?**
Please write the number that describes your trouble on the line below.

1	2	3	4	5
No trouble	Slight trouble	Moderate trouble	Considerable trouble	Could not do it

4) Climbing several flights of stairs ____

5) Crouching / Kneeling down ____

6) Walking at a brisk pace____

7) Going out for the evening, going to a wedding, a party, a cocktail party... ____

8) Playing a sport, exerting yourself ___

Lone Star Vein Center

Leg problems can also affect your spirits. How closely do the following statements correspond to how you have felt during the past four weeks?

Please write the number that describes your trouble on the line below.

1	2	3	4	5
Not at all	A little	Moderately	A lot	Completely

9) I felt nervous/tense____

10) I felt I was a burden____

11) I felt embarrassed about showing my legs____

12) I got irritated easily____

13) I felt as if I was handicapped____

14) I did not feel like going out ____