Thank you for choosing Dr. McHenry!

On behalf of Dr. McHenry and staff, we would like to take this opportunity to welcome you. We very much look forward to partnering with you to ensure the best care and treatment is achieved. We realize your time is valuable and we want to make every effort to ensure we meet your expectations efficiently.

To better serve you, we have provided you with important medical practice and policy information. This information will advise you as to what you can expect from your visit. Please carefully fill out all the required information in your packet. Please keep this information in a convenient location as a reference for you. Your participation in your care and treatment is essential to maximizing desired results.

Due to the highly specialized nature of our practice, your visit will consist of extensive visual testing and consultation. You can expect this to be a lengthy process of 90 minutes or more. Please allow plenty of time. We understand that this can be inconvenient at times, however, our primary concern is providing you with the utmost care and treatment. As our practice continues to expand, we gladly accept new patients. We appreciate your understanding.

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

What to Bring to Your First Appointment

Before you arrive, collect your medical records and imaging results, such as MRI films or X-rays. If you are not sure where these are, contact your referring physician.

NOTE: Dr. McHenry will perform a neuro-ophthalmic examination on each visit. Although at times, he may not dilate your eyes, you should expect to be dilated on each visit. Also, before seeing Dr. McHenry, you will go through a series of exams performed by our technicians.

BRING SUNGLASSES!

Please bring to your first appointment:

? **Driver's License or other photo identification**

? **Insurance Card (Policy Holder's Information If Necessary)**

? **Medical Records, Imaging Results (MRI films)**

? **List of Current Medications**

? **Referral Information**

? **Labs, CT, MRA, MRV, Lumbar Puncture Opening Pressure and Cerebrospinal Fluid Test Results (if you have them)**

Should you require further testing (Labs/MRI) or referral, additional appointments will be scheduled. Thank you for choosing our practice. We strive to provide the best possible medical care. It is our pleasure to welcome you as a patient!

Clinic Locations:

Dallas

1341 W. Mockingbird Lane
Suite 214W
Dallas, TX 75247

TEL 214.753.8500
FAX 214.753.8511

Grand Prairie

2210 N. Hwy 360
Grand Prairie, TX 75050

TEL 214.753.8500
FAX 214.753.8511

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

Patient Name:_____

Address:_____

City:_____ Zip:_____

MRN:_____

DOB:_____

SSN: XXXX-XX-_____ Sex:_____

DOS:_____

I.Consent for Treatment

I,_____am presenting myself to Dr. John G. McHenry M.D., M.P.H., P.L.L.C.
(Print Name of Patient)

For examination, diagnosis and/ or treatment of my medical condition. I give consent and authorize my physician(s) or his or her designees to order and/ or perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. John G. McHenry M.D., M.P.H. P.L.L.C., unless revoked by me in writing.

II.Consent for Disclosure of Information

I acknowledge that Dr. John G. McHenry is committed to protecting the confidentiality of information contained in my medical records, including my health and financial information (*Medical Records") in accordance with applicable laws and regulations. However, in order to provide treatment to me and to conduct billing and other health care operation activities, Dr. John G. McHenry M.D., M.P.H., P.L.L.C. requires permissions to disclose my Medical Records to certain individuals and entities.

Therefore, I give consent and authorize Dr. John G. McHenry, M.D., M.P.H., P.L.L.C. to disclose any or all information contained in my Medical Records including but not limited to information concerning communicable diseases such as human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS), alcohol and substance abuse, mental health diagnosis and treatment, and laboratory test results to the following individuals and entities:

Physicians and other health care personnel who are involved in the provision, coordination or management of my Health care, including but not limited to diagnosis, evaluation, treatment, consultation and referral for treatment.

My health insurance plan, Medicaid, Medicare, or any other personnel or entity that may be responsible for paying or processing payment for my medical treatment.

Employees, agents, representatives, volunteers or contractors of Dr. John G. McHenry, M.D., M.P.H., P.L.L.C. for the purpose of conducting health care activities including but not limited to administration, billing, compliance, quality assurance, risk management, credentialing and any other appropriate health care facility, activities or operations.

Any person or entity whom I give written authorization to receive my Medical Records on a form provided by Dr. John G. McHenry, M.D., M.P.H., P.L.L.C., or such other form acceptable to Dr. John G. McHenry, M.D., M.P.H., P.L.L.C. and:

Any other person or entity that is required or permitted by law to have access to my Medical Records.

I understand that the disclosure of my Medical Records may be necessary before my insurer will pay for the cost of my medical treatment and that by failing to authorize this disclosure I may be required to pay the entire bill. I understand that I may revoke this consent to disclose my Medical Records in writing at any time, except to the extent that Dr. John G. McHenry, M.D., M.P.H., P.L.L.C., has taken action pursuant to this consent. Any revocation of this consent will be effective upon receipt by Dr. John G. McHenry, M.D., M.P.H., P.L.L.C. I further agree not to hold Dr. John G. McHenry, M.D., M.P.H., P.L.L.C., his agents or employees liable for any damages as a result of disclosing my Medical Records in accordance with this consent.

Signature acknowledges that Patient and/ or Guardian has received these instructions and understands them.

Patient or Guardian Signature **Time/ Date** **Witnessed & Instructed by** **Time/ Date**

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

REFRACTION SERVICE AND FEE

A refraction is in the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

We may need to perform a refraction as part of the exam. If you are requesting glasses and a refraction that is not otherwise needed, there is a charge of $40.00.

Most medical insurance plans, including medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination since it is not a covered service.

Our office fee for refraction is $40.00 and must be collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction we will reimburse you accordingly.

If you have any questions regarding our insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

PRISM SERVICE AND FEE

A prism is used primarily for double vision, positional correction or convergence correction. Prism lenses are necessary to aid in helping the eyes work together. The use of prisms in the lenses trick the brain into thinking the eyes are working together by shifting the image slightly up, down, left or right.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination since it is not a covered service.

Our office fee for a prism is **$70.00** and must be collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the prism we will reimburse you accordingly.

If you have any questions regarding our insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Initial:_____

OFFICE FINANCIAL POLICIES

We are doing everything possible to hold down the cost of your medical care and provide good service. We appreciate your cooperation in this matter.

All Payments Are Expected At the Time of Service

Co-payments and self-payments are required at the time of service. Our practice accepts cash, checks, and most major credit cards. **There is a $25.00 service fee for returned checks.**

Insurance

- We need updated insurance information and card at every visit. If there is non-payment due to incorrect information or lapse/ change of current insurance, you will be responsible for all charges.

- We bill participating insurance companies and your secondary insurance, but cannot guarantee coverage of services.

- **Please verify your coverage before your visit.**

- **Patients are responsible for:**
  - Verifying with your insurance companies your full coverage and benefits. We are happy to provide you with the CPT codes.
  - Insuring that Dr. McHenry is In-Network with your provider (s).
  - Verifying all charges not covered by your insurance, deductible or out of network charges.
  - Verifying laboratory/ radiology services and location- we use Prime Imaging, Quest, and LabCorp. Please notify us ahead of time if you need to use another lab.
  - If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from your PCP before seeing a specialist. This is the patients responsibility to ensure a referral has been faxed. If no referral is on file, you will not be seen by the provider.

Billing

- If you need assistance or have any billing questions, please contact our Billing Department at **214-753-8465**

No-Show Appointments/ Late Cancellations:

- Please call 24 hours prior to your appointment.
- There will be restrictions on the times you will be able to reschedule your next appointment if you do not follow up.

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

Medical Record / Forms Fee

To obtain a copy of your medical records there is a $25.00 fee for the first 20 pages, and .50 cents per page thereafter.

Letters

Letters to Doctors listed on your Physicians form that summerizes your record, and any updates, requires a fee.

Referrals

If we refer you to another physician we will send your requested records free of charge.

Call **214-753-8471** if you have forms to fill out.
Call **214-753-8466** if you need to obtain records.

Patient Initial: _____

"Mending Fences for Your Vision"

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

RECORDS RELEASE POLICY

Our office receives numerous requests for copies of patient records every day. As you might imagine, the cost of providing these records can become a significant burden on our office's operational resources. We make every eff ort to respond to patients requesting a copy of their records as promptly and as inexpensively as possible. Due to the increasing costs and resources required to providing the copies, we require payment for records as allowed by Texas Medical Board. *Rule 165.2:*

> "The physician responding to a request for such information shall be entitled to receive a reasonable, cost-based fee for providing the requested information. A reasonable fee shall be a charge of no more than $25 for the first twenty pages and $.50 per page for every copy thereafter...A physician may charge separate fees for medical and billing records requested." *Rule 165.2(e)(1)*

> "The physician providing copies of requested medical and/or billing records or a summary or a narrative of such records shall be entitled to payment of a reasonable fee prior to release of the information..." *Rule 165.2(f)*

> "...the physician may retain the requested information until payment is received. If payment is not routed with such a request, within ten calendar days from receiving a request for the release of such records, the physician shall notify the requesting party in writing of the need for payment and may withhold the information until payment of a reasonable fee is received." *Rule 165.2(e)*

We are in direct compliance with the Medical Privacy law of Texas or H.B. 300.

Beginning September 2012, we will provide patients with electronic copies of their electronic health record within 15 business days of patient's written request.
Under HIPPA it was 30 days.

Please understand that we endeavor to make every patient's records available to them upon request. In order to ensure that we are paid for copies of a patient's medical records, as specifically permitted by the Texas Medical Board, we reserve the right to withhold or retain requested records until payment is received.

If you have any questions or concerns regarding this policy or a request for your records, please contact Medical Records at (214) 753-8466.

_____ _____

(Patient Signature) (Date)

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

New Patient Information

Personal Information (Please Print)

Name:_____ Date:_____

Date of Birth:_____ Age:_____ M___ F___ SS#_____

Address:_____
Street City State Zip

Phone:_____ Email:_____
Home Cell

Occupation:_____ Employer:_____

Address:_____ Phone:_____ Fax:_____

Marital Status: ____Single ____Married ____Widowed ____Divorced

COMPLETE IF UNDER 18 YEARS

Father:_____ Phone:_____

Address:_____

Mother:_____ Phone:_____

Address:_____

INSURANCE INFORMATION

Primary Insurance:_____

Policy Holders Name:_____ SS#:_____

DOB: _____ ID:_____ Group:_____

Secondary Insurance:_____

Policy Holders Name:_____ SS#:_____

DOB: _____ ID:_____ Group:_____

Tertiary Insurance:_____

Policyholder's Name:_____ SS#:_____

DOB: _____ ID:_____ Group:_____

____Workers Compensation

Policyholders Name:_____

Date of Injury:_____ Claim #:_____

EMERGENCY CONTACT Name:_____ Relationship:_____

Address:_____ Phone:_____

How did you hear about us: _____

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

Physician Information

Please list only Physicians that you wish for us to release your Patient information to. Physicians not listed on this form will not be given Patient information.

In the event of hospitalization or emergency where Patient is unable to complete this form, Patient information will be released to the Medical facility with presentation of a fax sheet.

Referring Physician

Name (Last, First)

Specialty

Address

City State Zip

Telephone Number

Primary Ophthalmologist

Name (Last, First)

Specialty

Address

City State Zip

Telephone Number

Primary Care Physician

Name (Last, First)

Specialty

Address

City State Zip

Telephone Number

Pediatrician

Name (Last, First)

Specialty

Address

City State Zip

Telephone Number

Other Physician

Name (Last, First)

Specialty

Address

City State Zip

Telephone Number

Other Physician

Name (Last, First)

Specialty

Address

City State Zip

Telephone Number

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

Medication Profile

Name: _____ **Date:** _____

Medication Allergies			

List all Prescription Medications and Eye Drops	

Supplements, Vitamins, Aspirin and any over the counter Drops and Medications	

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

Pharmacy Information

Patient Name:_____ **DOB:**_____

It is essential that you provide us with accurate and detailed information about your mail order and local pharmacy. If you are unsure of the address of your local pharmacy, please let us know at check-in. Complete this form and return it to the front office or the technician. Thank you.

E-Scribing is available! Please, we encourage all of our Patients to take advantage of our e-scribing service. This service electronically sends prescriptions directly to your specified pharmacy listed below. This process saves our Patient's valuable time.

Local Pharmacy Information:

Pharmacy:_____

Address:_____

_____

Phone:_____

Fax:_____

90-Day/ Mail Order

- ☐ Aetna RX Home Delivery
- ☐ Caremark Mail Order
- ☐ Express Scripts Medco Mail Order
- ☐ PharmaCare
- ☐ Prescription Solutions
- ☐ Prime Therapeutics
- ☐ Walgreen's Mail Service
- ☐ Wellpoint NextRx Mail
- ☐ Other

Patient Initial:_____

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

REVIEW OF SYSTEMS

Patient Name:_____ SS#_____ Date of Birth:_____

Do you currently have any of the following problems?

System Please Circle and Provide Information		Date Diagnosed	
Eyes (blur, glare, red, pain, etc.)	**None**		
General/ Constitutional (fever, weight loss, other)	**None**		
Ears, Nose, Throat (stuffy nose, ear ache, cough, dry mouth, etc.)	**None**		
Cardiovascular (high blood pressure Racing pulse, ect.)	**None**		
Respiratory (congestion, wheezing, etc.)	**None**		
Gastrointestinal (stomach ulcers, intestinal disease, etc.)	**None**		
Genital, Kidney, Bladder (painful urination, impotence etc.)	**None**		
Muscles, Bones, Joints (joint pain, Stiffness, swelling, cramps, etc.)	**None**		
Skin (pimples, warts, growths, rash etc.)	**None**		
Neurological (numbness, stroke, headaches, etc.)	**None**		
Psychiatric (anxiety, depression insomnia)	**None**		
Endocrine (diabetes, hypothyroid, etc.)	**None**		
Blood/Lymph (bleeding tendency, anemia)	**None**		
Allergic/Immunologic (sneezing swelling, redness, itching, hives, etc.)	**None**		
Cancer (Type):	**None**		
Frequent Infections	**None**		
Corticosteroid treatment	**None**		

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

PAST MEDICAL HISTORY

Name:_____ Date:_____

Diabetes Mellitus? _____ YES_____NO Insulin Treatment? _____YES_____ NO

Myocardial Infarction in past 6 - 12 months? _____ YES_____ NO If yes, DATE: _____

Hypertension?_____YES_____NO

Exposure to contagious disease: _____ YES_____ NO If yes, list disease: _____

List Medical Problems:

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____

Previous Hospitalizations:

1)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

Previous Surgery:

1)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

WHAT IS THIS NOTICE?

This notice tells you:

How we use and release your health information

Your rights concerning your health information

Our responsibilities to protect your health information.

TO WHOM DOES THIS NOTICE APPLY?

This notice applies to:
Any member or volunteer group who may help you while you are seeking health care at John G. McHenry, M.D., M.P.H., P.L.L.C.

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 disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
We may say "no" to your request, but we'll tell you why in writing within 60 days.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care

Share information in a disaster relief situation

Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Most sharing of psychotherapy notes

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

Preventing disease

Helping with product recalls

Reporting adverse reactions to medications

Reporting suspected abuse, neglect, or domestic violence

Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

For workers' compensation claims

For law enforcement purposes or with a law enforcement official

With health oversight agencies for activities authorized by law

For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Texas Laws

Effective September 1, 2012, the **Texas Medical Records Privacy Act** provides additional protections to consumers. The Act is broader in scope than HIPAA because it applies not only to health care providers, health plans and other entities that process health insurance claims but also to any individual, business, or organization that obtains, stores, or possesses protected health information (PHI) as well as their agents, employees and contractors if they create, receive, obtain, use or transmit PHI.

Under the Act, these individuals, businesses and organizations must comply with several requirements including mandatory training for employees regarding PHI. In most instances, the Act prohibits covered entities from using or disclosing PHI without first obtaining an individual's authorization.

Overview of Your Rights under State and Federal Laws

Right of Access to Health Records

State and federal laws give you the right to ask to review and obtain a copy of your health records from most health care providers such as doctors, hospitals, pharmacies and nursing homes, as well as from your health plan. Your provider may have a form you can use to request your records. In a few special cases, such as instances in which your doctor decides that information in the file may endanger you, you may not be able to obtain all of your information.

A provider may charge for the reasonable costs of copying and mailing your records if you request copies and mailing but may not charge a retrieval fee.

Texas law specifies that if the provider is using an electronic health records system capable of fulfilling the request, the records must be provided not later than the 15th business day after the date your provider receives your written request. The records must be provided to you in electronic form unless you have agreed to accept the records in another form.

Right to amend information in your health records

If you believe that information in your medical records is incorrect, you have the right to request that the provider or health plan correct or amend the record and they must respond to your request. If the provider or health plan does not agree to make your requested corrections, they must notify you in writing and tell you why your request was denied. You have the right to submit a statement of disagreement that the provider or plan must add to your record.

Right to know how your personal health information will be used and shared and to limit who gets to see it

Your provider or health plan must give you a notice of their privacy practices that informs you of three things: (1) the uses and disclosures of your PHI which they are permitted to make; (2) other disclosures which require your authorization; and (3) that in the event of a breach of unsecured PHI, you will receive a notice of that breach. This notice of privacy practices will generally be provided on your first visit to a provider or in the mail from your health plan. You can also obtain a copy at any time that you request it.

In general, your health information cannot be used or shared for other purposes including sales calls or advertising, unless you first give your permission by signing a form authorizing such use. The authorization form must tell you who will get your information and what your information will be used for. Generally, this type of authorization is not required if the disclosure of your health information is for the purpose of treatment, payment, health care operations or performing certain insurance or health care maintenance organization functions.

Under certain circumstances, a covered entity may disclose PHI without the authorization of the person who is the subject of the protected information. Those circumstances include, but are not limited to, disclosures made to or in connection with a health oversight agency for audits and investigations, a threat to public safety, and situations involving victims of abuse or neglect. Also, if you are incapacitated or in an emergency, providers sometimes may use or disclose your PHI without your authorization if, in the exercise of medical judgment, they determine it is in your best interests. Your PHI may also be disclosed without your authorization if the disclosure is required by law, including a subpoena or court order.

Right to limit marketing uses of protected health information

In general, your health information cannot be used or shared for marketing communications without your authorization. Certain exceptions apply including face to face communications between a covered entity and an individual. If your PHI is used or disclosed to send a written marketing communication through the mail, that mailing must include the name and toll free number of the entity which sent you the marketing communication and an explanation of your right to have your name removed from the sender's mailing list. In addition, the mailing must be in an envelope which shows only the name and address of the sender and recipient.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

You can contact our privacy official at SYousuf@johngmchenrymd.co

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.
1341 West Mockingbird, Suite 240
Dallas, Texas 75247
Ph: 214-862-2243
Fx: 972-243-2670
contactus@johngmchenrymd.com
www.johngmchenrymd.com

Signature acknowledges that patient and/or guardian has received these instructions and understands them.

Parent or Guardian Signature	Time/Date	Witnessed or Instructed by	Time/Date

INFORMATION REGARDING EXAMINATION AND DILATING EYE DROPS

Dr. McHenry will perform a neuro-ophthalmic examination on each visit. Although at times he may not dilate your eyes, you should expect to be dilated on **each** visit.

Dilating drops are used to dilate or enlarge the pupils of the eye to allow ophthalmologists to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for Dr. McHenry to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. Adverse reactions are rare and treatable but can lead to visual changes if left untreated. If you cannot be dilated due to medical reasons, please let the ladies at the front desk know about your medical condition upon checking into the clinic so proper arrangements can be made by the office.

Dr. McHenry must dilate your eyes in order to conduct a proper eye examination. If you do not wish to be dilated in order for your eye examination, we will suggest other neuro-ophthalmologists for you to see.

I hereby authorize John G. McHenry, M.D., M.P.H., P.L.L.C. and/or such assistants as may be designated by him to administer dilating eye drops during my visits. The eye drops are necessary to diagnose my condition and to determine interval changes.

Patient Name_____ Date_____

Patient Signature_____ Date_____
(or authorized caregiver/legal guardian)

Witness Date_____ Date_____

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

Family History

Has anyone in your family ever had the following? If so, please indicate M-Mother, F-Father, S-Sibling, G-Grandparent.

	Yes	No	Family Member
Arthritis			
Blindness			
Cancer			
Cataracts			
Diabetes			
Glaucoma			
Heart Disease			
High Blood Pressure			
Other Eye Problems			
Stroke			
Retinal Eye Disease			
Thyroid Disease			
Other			

Please list any other diseases

_____

_____

_____

Social History

Do you drink alcohol? _____ Yes _____ No If yes how much? _____

Do you smoke? _____ Yes _____ No If yes how much? _____

Do you use other tobacco products? _____ Yes _____ No If yes how much? _____

** For Information on quitting please visit www.cancer.org **

Does your vision limit any activities of daily living (driving, reading, sports, work)? ___Yes ___ No

Have you ever had a blood transfusion? ___Yes ___ No

JOHN G. MCHENRY, M.D., M.P.H., P.L.L.C.

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

It is against HIPPA Law to give out privileged healthcare information without authorization.

Dr. McHenry will not speak to, disclose information to, or consult with anyone regarding your case without your permission

Dr. John McHenry may disclose personal healthcare information to:

1. _____
2. _____
3. _____

If you wish to update, please call: 214-753-8466

Patient Name : _____

Date: _____

Signature: _____

JOHN G. McHENRY, M.D., M.P.H., P.L.L.C.

OFFICE PROCEDURES AND FINANCIAL POLICIES AGREEMENT

I have read and understand **Prism and Refraction Fee Policies**, and understand that these are non-covered services. I accept full financial responsibility for the cost of this service, and understand that payment is due at the time of service. I understand that any co-payment, co-insurance, or deductible I may have are separate from and not included in these fees.

I have read and understand the **Financial Policies and Procedures** and acknowledge that I am responsible for any insurance, medical records, refraction, prism, lab and/ or radiology fees I may incur.
I agree to assign insurance benefits to Dr. John G. McHenry whenever necessary. I also agree that if it became necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative,

_____ _____

Patient Signature (Parent for Minor) **Date**

_____

Print Name

Clearance for Driving

If you are told by your doctor that you cannot drive and are being sent to the eye doctor to be cleared for driving, be advised that we will clear you only to take a driver's rehabilitation course. There are many things that are involved with driving. Vision is only part of the equation. Processing reference information, coordinating, strength and the ability to sit and use controls are also important. Because of the potential damages imposed to the public, if you are advised by Dr. McHenry to take a driver's rehabilitation course and decline to do so, Dr. McHenry will turn your name into the State to have your driver's license revoked. The State of Texas specifically removes the assessment of driving abilities from presumed doctor-patient confidentiality. The lives of others are at stake. Texas Law is designed to protect the public. Dr. McHenry will not take responsibility for your driving against medical advice. The law offers protection to physicians who report patients who should not be driving.

Patient Signature

Today's Date

New Patient Worker's Compensation Form

John G. McHenry M.D. practice does not see patients who are going through Worker's Compensation or have an existing open claim. By signing this, I certify that I am not being seen for injuries arising out of a Worker's Compensation case.

_____ _____

(Patient Signature) **(Date)**

Letter Acknowledgement

Dr. McHenry will not sign any letters presented by attorneys or patients

_____ _____

(Patient Signature) **(Date)**

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