

General History

Patient Name: _____ Date: _____ DOB: _____ Sex: Male/ Female

1. Allergies: _____

2. How did you hear about us? Family/Friend__ Insurance__ Doctor_____Other__

3. Occupation: _____

3. History of following diseases

check if YES):	Self	Family		Self	Family
EYE DISEASE			Respiratory		
1. CATARACTS			1. Asthma		
2. GLAUCOMA			2. Bronchitis		
3. MACULAR DEGENERATION			3. Emphysema		
4. RETINAL DETACHMENT			4. Oxygen dependence		
Cardiac			Gastrointestinal		
1. Heart disease			1. GI reflux		
2. High blood pressure			2. Hiatal hernia		
3. Chest pain			3. Hepatitis (Type:____)		
Neurological			Ear/Nose/Throat		
1. Stroke			1. Chronic cough		
2. Seizures			2. Hearing aid use		
Kidney			Psychiatric		
1. Renal insufficiency/failure			1. Depression		
2. Dialysis dependence			2. Anxiety		
Endocrine			Other		
1. Diabetes (Type____)			1. Cancer (Type:____)		
2. Thyroid problems			2. HIV		
Musculoskeletal			3. Bleeding disorders		
1. Walker/wheelchair use			4. _____		
2. Joint pain (Location:____)			5. _____		

4. Current Medications: _____

5. Previous Surgeries: _____

6. Tobacco use: Yes/ No Quantity: _____ If you quit,how long ago? _____

7. Alcohol consumption? Yes/ No Quantity: _____

8. Drug abuse? Yes/ No Type: _____

9. If you are female, possibility of pregnancy? Yes/No

10. Do you suffer from any of the following?

Blurry Vision	_____	Sinus Problems	_____	Dry Eyes	_____
Flashes of Light	_____	Headaches	_____	Halos	_____
Watery Eyes	_____	Pain in your eyes	_____	Floaters	_____
Seasonal Allergies	_____	Dizziness	_____	Other	_____

11. Do you wear glasses or contact lenses? Yes/ No Extended Daily Hard Soft

Signature: _____

Physician's signature: _____ Date: _____

Subsequent History reviews (check, sign, and date):

___ No changes	___ Additions as noted above	_____	Date: _____
___ No changes	___ Additions as noted above	_____	Date: _____
___ No changes	___ Additions as noted above	_____	Date: _____

Methodist Eye Associates

Signature on File, Assignment of Benefits, Financial Agreement HIPAA Notice

Name: _____

Date: _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Methodist Eye Associates for services rendered to me by Doctor(s). I authorize any holder of medical information to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Methodist Eye Associates accepts the charge of determination of the Medicare carrier as the full charge, and I am responsible for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in item 9 of the HCFA 1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Methodist Eye Associates, if possible, or otherwise to me.

OTHER INSURANCE: I authorize payment of my medical and surgical insurance benefits to Methodist Eye Associates. I understand I am financially responsible for any charges whether or not paid by insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Methodist Eye Associates. I authorize Methodist Eye Associates to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

NON-COVERED SERVICES: I understand that Methodist Eye Associates contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all the items or services. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. I agree to cooperate with Methodist Eye Associates to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for services provided to me by Methodist Eye Associates, I will pay my bill at the time service is rendered. If my account is sent to an agency for collection, I agree to pay collection expenses. Any benefits of any type under any policy of insurance are hereby assigned to Methodist Eye Associates. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Methodist Eye Associates. However, I understand that I am primarily responsible for the payment of my bill.

HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices Issued by Methodist Eye Associates that was effective May 1, 2011. I agree to allow electronic communication as defined in security practices effective April 21st, 2005.

INFORMATION TO BE USED BY OR DISCLOSED TO:

Name of Recipient (Family Member): _____

Telephone Number: _____ Fax Number: _____

I have read and understand these instructions and have a copy for my review.

Signature: _____

Please direct complaints to: Texas Department of State Health Services 110 West 49th Street, Austin, Texas 78756 Phone: 1-888-973-0022

Methodist Eye Associates

Refraction Policy

During your visit, a refraction test may be necessary to determine your need for glasses or to evaluate if any further visual improvement can be achieved. If performed, it is because it is necessary and essential to your eye exam and in some cases it is the sole reason for the appointment.

Many insurance companies, including Medicare, do not cover this service. Because the service is not covered, the patient is responsible for the cost of the refraction test. The fee is \$50.00. This fee is in addition to the fees for the eye exam. If you have a copay for your eye exam, you will need to pay both your co-pay and the \$50.00 for the refraction test.

We appreciate your cooperation in paying this fee at the time services are rendered.

CONTACT LENS POLICY

The glasses prescription you receive from Methodist Eye Associates is **NOT** a contact lens prescription. A qualified contact lens fitter must fit the contact lenses. There is a fee for this service, which varies greatly depending on the type of contact lenses, whether you have been fitted before, and other individual factors. You will receive a copy of your contact lens prescription **only** if you have completed the fitting and made payment for the service.

I have read and understand the above refraction and contact lens policy.

Patient or Guardian Signature

Date

TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS
NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

This Notice of Privacy Practices identifies the general ways your protected health information can be used or disclosed. Protected health information is the individually identifiable personal health information found in your medical and billing records. This information is created or received by a health care provider, insurance company, or employer, and relates to your past, present, or future physical or mental health conditions or the payment for health care services. This information can be transmitted or maintained in any form by TMH Physician Organization and its Physicians.

This Notice describes your legal rights regarding your health information. It also informs you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated in the individual offices of each physician of TMH Physician Organization. If you receive services by your physician or a health care provider at a different location, there may be different health information privacy policies or notices, and there will be different contact information.

For the purpose of this Notice, the terms "TMH Physician Organization and its Physicians," "TMH Physician Organization," "we" and "our" refer to TMH Physician Organization as an organization as well as each individual physician affiliated with the TMH Physician Organization, with respect to health information generated or maintained by TMH Physician Organization's physicians.

OUR LEGAL DUTIES

We are required, by law, to keep your identifiable health information private; provide you with this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice as long as it is in effect. If we revise this Notice, we will follow the terms of the revised Notice, as long as it is in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following information describes how we are permitted, or required by law, to use and disclose your health information. Not every use or disclosure in a category will be listed.

Treatment: We may use or disclose your health information to a physician or other health care provider in order to provide care and treatment to you. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose health information about you to those who may be involved in your health care outside of TMH Physician Organization, such as hospitals, physicians, and others who provide you with follow-up care and medical equipment or product suppliers. We may contact you to provide appointment reminders and to provide you with information about health-related benefits and services provided by TMH Physician Organization or by The Methodist Hospital System, or treatment alternatives that may be of interest to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. We may disclose your health information to another health care provider or entity. For example, we may need to provide your health plan with information about surgery you received so your health plan will pay TMH Physician Organization or reimburse you for the surgery. TMH Physician Organization also will tell your health plan about a treatment you are going to receive to obtain the health plan's prior approval for this treatment or to determine whether your plan will cover the treatment.

Health Care Operations: We may use or disclose health information about you to support the programs and activities of TMH Physician Organization and The Methodist Hospital System such as quality and service improvement; health care delivery review; staff performance evaluation; competence or qualification review of health care professionals; education and training of physicians and other health care providers; and business planning and development, business management and general administrative activities. We use this information to continuously improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements.

Additionally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Health Information Exchange: We may make your health information available electronically through an information exchange service to other providers involved in your care who request your electronic health information. Participation in information exchange services also lets us see their information about you. The purpose of this information exchange is to support the delivery of quality patient care.

Authorization for Other Disclosures: We will not use or disclose your health information, except as described in this document, unless you authorize us, in writing, to do so. You can revoke an authorization at any time, in writing. If you revoke an authorization, we will no longer use or disclose your health information for the purpose covered by the authorization. However, we are unable to take back any uses or disclosures already made with your authorization. Specific examples of uses or disclosures requiring authorization include: use of psychotherapy notes, marketing activities, the sale of your health information and most uses and disclosures for which we are compensated.

Family and Friends: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition. We will also disclose health information to a family member, other relative, close personal friend, or any other person you identify, if the information is relevant to that person's involvement with your care or payment for your care. You can prohibit disclosure of this information.

Fundraising: We may use or disclose health information about you to contact you in an effort to raise money for our organization and its operations. We may disclose this information to The Methodist Hospital Foundation to assist us in our fundraising activities. Only contact information such as your name, address and telephone number, and the dates you received treatment or services at TMH Physician Organization would be released. You have the right to opt out of fundraising communications at any time and your request must be honored. Any such communication will have clear and conspicuous instructions on how to opt out of future communications.

Future Communications: We may use or disclose your information to communicate with you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which TMH Physician Organization participates. If we receive any financial compensation for such communications, we will inform you. You have the right to opt out of receiving such compensated communications at any time and we must honor your request. Any such communication will have clear and conspicuous instructions on how to opt out of future communications.

Public Health and Safety: We may use or disclose health information, as authorized or required by local, state or federal law, for the following purposes deemed to be in the public interest or benefit:

- To report certain diseases and wounds, births and deaths, and suspected cases of abuse, neglect, or domestic violence;
- To help identify, locate, or report criminal suspects, crime victims, suspicious deaths, or criminal conduct on the premises of TMH Physician Organization's physicians;
- To respond to a court order, subpoena, or other judicial process;
- To assist federal disaster relief efforts;
- To enable product recalls, repairs, or replacements;
- To respond to an audit, inspection, or investigation by a health-related government agency;
- To assist in federal intelligence, counterintelligence, and national security issues;
- To facilitate organ and tissue donations;
- To assist coroners, medical examiners, and funeral directors;
- To respond to a request from a jail or prison regarding an inmate's health or medical treatment;
- To respond to a request from your military command authority (if you are a member or veteran of the armed forces);
- To provide information to a workers' compensation program.

Business Associates: There are some services provided at TMH Physician Organization and its Physicians through contracts with business associates. When these services are contracted, we will disclose your health information to the business associate so they can perform the job we have asked them to do. However, business associates are required by federal law to appropriately safeguard your information.

Research: We will disclose information to researchers after approval by an Institutional Review Board (IRB) in preparation for a research study, to recruit research subjects, or for a research study. The IRB reviews research proposals and establishes protocols to protect your safety and the privacy of your health information.

Special Privacy Protections for Alcohol and Drug Abuse Information: Alcohol and drug abuse information has special privacy protections. We will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient consents in writing; a court order requires disclosure of the information; medical personnel need the information to meet a medical emergency; qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

YOUR HEALTH INFORMATION RIGHTS

Your medical record that is created after your physician has affiliated with TMH Physician Organization is the property of TMH Physician Organization. You have the following rights, with certain exceptions, regarding the health information that is created about you by TMH Physician Organization and its Physicians.

You have the right to a paper copy of this Notice. In addition, a copy of this Notice also may be obtained at our web site, www.methodisthealth.com.

Confidential Communications: You have the right to request that we communicate health information to you by an alternate means or location other than your home address and telephone number. Your request must be made in writing to TMH Physician Organization's contact person, and must specify how or where you wish to be contacted. We will try to accommodate your request for alternate communications. If you request an alternate means of communication, that request also should be communicated by you to all of your physicians, including your private physician.

Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. To request a restriction, you must make your request in writing to the listed contact person. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Additionally, you have the right to request that we not use or disclose information to a health plan for purposes of payment or health care operations (not for treatment) if the health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. Your request for restriction must be submitted in writing to our listed contact person. In this case, TMH Physician Organization must honor your request. However, you should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

Access: You have the right to review and obtain a copy of your health information, with certain exceptions. Usually, this includes medical and billing records, but does not include psychotherapy notes. Your request to review or obtain a copy of your health information must be in writing to our listed contact person. You will be charged fees as authorized by law. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Amendment: If you feel that the health information we have about you is incorrect or incomplete, you have the right to ask for an amendment of that information. You have the right to request an amendment for as long as the information is kept by or for us. Your request for an amendment must be made in writing to our listed contact person, and include a reason that supports your request.

Accounting of Disclosures: You have the right to receive a list of certain disclosures that we have made within the last six years of your health information. Your request for an accounting must be in writing to our listed contact person, and must state a time period for which you want an accounting. You may request one accounting free of charge within a 12-month period. A fee will be charged for additional lists within this same time period.

Breach Notification: In certain instances, you have the right to be notified in the event that we, or one of our Business Associates, discover an inappropriate use or disclosure of your health information. Notice of any such use or disclosure will be made in accordance with state and federal requirements.

Revisions of this Notice: We reserve the right to change this Notice, and the right to make the new provisions effective for all health information we currently maintain, as well as any information we receive in the future. If we make a major change to this Notice, the revised Notice will be posted in the individual offices of Physicians of TMH Physician Organization and on TMH Physician organization's web site. In addition, a paper copy of the revised Notice will be available upon request.

To Report a Complaint: If you believe your health information privacy rights have been violated, you can file a complaint with us or with the Secretary of the United States Department of Health and Human Services. There will not be any penalty or retaliation against you for making a complaint to us or to the Department of Health and Human Services.

Contact Person: If you have any questions or need information regarding our legal duties and privacy practices, or how to exercise any of your health information rights listed in this Notice, please contact:

**Privacy Official
The Methodist Hospital System
1130 Earle Street AX200
Houston, Texas 77030
713.383.5129**