Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care

7406 N. La Cholla Blvd
Tucson, Arizona 85741
520-545-0202
www.headtotoehealthcare.org

# 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 IT CAREFULLY.**

Head to Toe Healthcare PLC (H2T) collects health information about you or your dependents and stores them in a paper or electronic chart record. The medical record is the property of this medical practice but the information is yours. The law permits H2T to use or disclose the health information for the following purposes:

**How This Medical Practice May Use or Disclose Your Health Information:**

**Treatment.** H2T may use and disclose your medical information to H2T employees and others who are involved in providing the care you need. This includes but not limited to, referral to other physicians, healthcare facilities, pharmacies, laboratories, and family members if necessary.

**Payment.** H2T may use and disclose your medical information to obtain payment for the services H2T provide. This includes but not limited to, insurance verification/eligibilities, claims, collections and benefits coordination with other/third parties.

**Heatlh Care Operations,** H2T may use and disclose your medical information to operate H2T. This includes but not limited to, administrative and managerial functions, financial or billing audits, benefit coverage, internal quality assurance, claims submissions through clearinghouses, manage care participations, personnel decisions, defense of legal matters, business/compliance planning, legal services, fraud and abuse detection and H2T business associates.

**Appointment Reminders.** H2T may use and disclose your medical information to contact and remind you about your appointments; via phone/text/email or mail unless you inform H2T otherwise. H2T could leave a message on your answering machine or with the person who answers the phone when you are not available.

**Sign/Check In.** H2T may use and disclose your medical information to call out your name when you are ready to be seen.

**Family Notification and Communication.** H2T may use and disclose your medical information to notify/assist in notifying family members, your representatives or personnel that are responsible for your care unless you instruct H2T otherwise and during emergency circumstances. If you are unable or available to agree or object, H2T health professionals will use their best judgment in communicating with your family and others as they see appropriate.

**Marketing.** H2T may use and disclose your medical information to give you information about products/services that might be of interest to you such as potential treatment alternatives/options and health related benefits.

**Sale of Health Information.** H2T will not sell your health information without your prior written authorization unless there's a change in ownership of this medical practice. In that event, you have the right to request your health information transferred to another physician or medical practice.

**Required by Law.** As required by law, H2T may use and disclose your health information when the law requires H2T to report abuse, neglect or domestic violence or respond to judicial administrative proceedings or to assist law enforcement officials.

**Public Health.** As required by law, H2T may use and disclose your health information to public health authorities such as CDC, FDA to prevent or control disease, injuries or disability, or for other health oversight activities.

**Coroners, Medical Examiners and Funeral Directors.** H2T may use and disclose your medical information to coroners in connection with death investigation as permitted by law.

**Organs or Tissue Donation.** H2T may use and disclose your medical information to organizations involving in procuring, banking or transplanting organs and tissues.

**Public Safety.** H2T may use and disclose your medical information to appropriate persons in order to prevent or lessen a serious and imminent threat to health or safety of individual or others.

**Specialized Government Functions.** H2T may use and disclose your medical information to correctional institutions, law enforcement officers that have you in custody and for military or national security purposes.

**Workers' Compensation.** H2T may use and disclose your medical information to comply with workers' compensation laws.

Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care

7406 N. La Cholla Blvd
Tucson, Arizona 85741
520-545-0202
www.headtotoehealthcare.org

**Breach Notification.** In case of a breach of unsecured protected health information, we will notify you as required by law. H2T may use your current e-mail to communicate or other methods when available and in some circumstances our business associates may provide the notification on H2T behalf.

**Research.** H2T may use and disclose your medical information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with government law.

**Fundraising.** H2T may use and disclose your demographic information to inform you of our fundraising activities.

**When H2T May Not Use or Disclose Your Health Information:**

Except as described in this Notice of Privacy Practices, H2T will not use or disclose your health information which identifies you without your written authorization. If you do authorize H2T to use or disclose your health information for another purpose, you may revoke the authorization in writing at any time.

**Your Health Information Rights:**

**Right to Request Special Privacy Protections/Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information by written request specifying what information you want to limit and what limitations on H2T use or disclosure you wish H2T to impose such as your fully paid out-of-pocket expenses; unless H2T must disclose them for your continuation of treatment or legal reasons. H2T reserved the right to accept or decline your request.

**Right to Request Confidential Communications.** You have the right to request how you receive your health information through alternative means or location. H2T will consider all reasonable request submitted in writing and reserve the right to accept or decline your request.

**Right to Inspect and Copy.** You have the right to inspect and copy your health information with limited exceptions. Request must be submitted in writing detailing what information you want to access. H2T will charge a fee to cover H2T costs for labor, supplies, postage and cost of preparing an explanation or summary.

**Right to Amend or Supplement.** You have the right to request H2T to amend your health information that you believe is incorrect or incomplete in writing and include the reasons for your request. H2T reserved the right to accept or decline your request.

**Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information made by H2T, except that H2T does not have to account for disclosures provided to you or pursuant to your written authorization or as described in Treatment, Payment, Health Care Operations, Family Communication and Notification and Specialized Government Functions of this Notice of Privacy Practices or use or disclosure permitted by law. H2T will charge a fee to cover H2T costs for labor, supplies, postage and cost of preparing an explanation or summary.

**Right to a Paper or Electronic Copy of this Notice.** You have the right to receive a paper copy of this Notice of Privacy Practices at any time.

**Right to Revoke Permission.** You have the right to revoke your authorization to use and disclose you health information at any time, except to the extent that action has already been taken.

**Changes to this Notice of Privacy Practices:**

H2T reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, H2T is required by law to comply with the terms of this Notice currently in effect. Revised Notice will be made available to you.

**Complaints:**

If you believe are not satisfied with the manner in which H2T handles your health information, you may direct your concern in writing to H2T Privacy Officer addressed above. You may also submit a formal complaint with the Secretary of the Department of Health and Human Services. H2T will not retaliate against you for filling a complaint.

**Effective Date of this Notice: September 21, 2013**

Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care

7406 N. La Cholla Blvd
Tucson, Arizona 85741
520-545-0202
www.headtotoehealthcare.org

## INSURANCE INFORMATION

**Patient's Name:** _____ **Date of Birth:** __ ___/_____/_____
**Social Security Number:** _____-_____-_____

**VISION INSURANCE**
**Insurance Provider:** _____
**Member ID #:** _____ **Group #:** _____
**Insured Name:** _____ **Insured Birth Date:** _____/_____/_____
**Insured Employer:** _____ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

**PRIMARY MEDICAL INSURANCE**
**Insurance Provider:** _____
**Member ID #:** _____ **Group #:** _____
**Insured Name:** _____ **Insured Birth Date:** _____/_____/_____
**Insured Employer:** _____ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

**SECONDARY MEDICAL INSURANCE (IF APPLICABLE)**
**Insurance Provider:** _____
**Member ID #:** _____ **Group #:** _____
**Insured Name:** _____ **Insured Birth Date:** _____/_____/_____
**Insured Employer:** _____ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

☐ **Were H2T COVID-19 and HIPAA – Notice of Privacy Practices form made available to you? _____ (Please initial)**

***(Eye patients)***
**Head to Toe Healthcare PLC – *Advanced Eye and Foot Care* provides comprehensive routine and medical eye exams. This includes not only vision correction but also screenings for other ocular conditions and systemic diseases. During your vision examination, should a medical condition arise, be advised that it is not covered under your routine eye benefits through your vision insurance plan. Medical exams are billed through your Major Medical Carrier and are subjected to their specific Co-pays, Deductibles, Co-insurance and will be due at the time of service. In the event that I do not wish the Doctor to proceed with a medical examination, I understand that it is my responsibility to immediately inform the doctor as she/ he can refer me to the appropriate specialty doctor.**

***(Eye and foot patients)***
**I hereby authorize any payment for my services today to Head to Toe Healthcare PLC – *Advanced Eye and Foot Care*. I understand that if my employer, insurance carrier or plan sponsor refuses payment to any portion of my claim, I am financially liable and responsible for the outstanding balance/ charges on my account. Any unpaid balance on my account or my family's account is subjected to 1.5% per month interest rate or 18% per year. Should there be any legal action filed, I am responsible for the collection fees, attorney fees, filling fees, and any cost the court determines. Obtained authorization does not guarantee payment and any denied services will be billed to the patient.**

**I am aware that Head to Toe Healthcare PLC is out-of-network with AHCCCS, Medicaid or any of their affiliated entities.**

**Patient/ Guardian Signature:** _____ **Date:** _____/_____/_____

Rev 2020

**Name:**_____ **Guardian (If applicable):**_____

**Address:**_____ **Today's Date:**_____/_____/_____

**City:**_____ **State:**_____ **Zip:**_____ **Home Phone:** _____-_____-_____

**Birth Date:**____/____/____ **Social Security (opt):**_____ **Email:** _____

**Occupation:**_____ **Employer:**_____ **Work Phone:** _____-_____-_____

**Primary Care Physician:**_____ **Cell Phone:** _____-_____-_____

**PCP Address:**_____ **Last Medical Exam:**_____

**Previous Eye Physician:**_____ **Last Eye Exam:**_____

**How did you hear about us?**_____

☐ **Was the HIPAA – Notice of Privacy Practices form made available to you? _____(Please initial)**

**1) EYE CHIEF COMPLAINT (TODAY)**

| | | | |
|---|---|---|---|
| **Blurred Vision** | **Yes ☐ No ☐** | **Foreign Body Sensation** | **Yes ☐ No ☐** |
| **Burning** | **Yes ☐ No ☐** | **Glare/ Light sensitivity** | **Yes ☐ No ☐** |
| **Eye/ Lid Infection** | **Yes ☐ No ☐** | **Itching** | **Yes ☐ No ☐** |
| **Distorted Vision/ Halos** | **Yes ☐ No ☐** | **Loss of Side Vision** | **Yes ☐ No ☐** |
| **Double Vision** | **Yes ☐ No ☐** | **Loss of Vision** | **Yes ☐ No ☐** |
| **Dryness** | **Yes ☐ No ☐** | **Mucous Discharge** | **Yes ☐ No ☐** |
| **Excess Tearing/ Watering** | **Yes ☐ No ☐** | **Redness** | **Yes ☐ No ☐** |
| **Eye Pain/ Soreness** | **Yes ☐ No ☐** | **Sandy/ Gritty Feeling** | **Yes ☐ No ☐** |
| **Flashes/ Floaters in Vision** | **Yes ☐ No ☐** | **Tired Eyes** | **Yes ☐ No ☐** |

**If you answered *Yes* to any of the above or have a condition not listed, please explain:**_____

_____

**2) OCULAR CONDITIONS**

| | | | |
|---|---|---|---|
| **Glaucoma** | **Yes ☐ No ☐** | **Blindness** | **Yes ☐ No ☐** |
| **Cataracts** | **Yes ☐ No ☐** | **Crossed Eyes/Strabismus** | **Yes ☐ No ☐** |
| **Macular Degeneration** | **Yes ☐ No ☐** | **Lazy Eye/Amblyopia** | **Yes ☐ No ☐** |
| **Eye Injury** | **Yes ☐ No ☐** | **Diabetic Retinopathy** | **Yes ☐ No ☐** |
| **Retinal Disease/Condition** | **Yes ☐ No ☐** | **Dry Eyes** | **Yes ☐ No ☐** |
| **Other Ocular Condition** | **Yes ☐ No ☐** | **Refractive Surgery** | **Yes ☐ No ☐** |

**3) MEDICAL HISTORY**

**Do you have any allergies or allergies to medication?**

_____

**List ANY medications you take prescription or over the counter:**

_____

**List ALL current health conditions:**

_____

**List ALL major injuries, surgeries and hospitalization:**

_____

| | | | |
|---|---|---|---|
| **Are you pregnant or nursing?** | **Yes ☐ No ☐** | | |
| **Do you wear glasses?** | **Yes ☐ No ☐** | **How old is your present pair?** | _____ |
| **Do you wear contact lenses?** | **Yes ☐ No ☐** | **How old is your current pair?** | _____ |
| **What type of contact lenses?** | **Hard ☐ Soft ☐** | **Do you sleep in them?** | **Yes ☐ No ☐** |
| **Are they comfortable?** | **Yes ☐ No ☐** | **How often do you change/dispose of your CL?** | _____ |
| **Interested in refractive surgery?** | **Yes ☐ No ☐** | | |

**4) FAMILY HISTORY**

| **Disease/ Condition:** | **If yes, please indicate which relative; specify maternal or paternal if necessary** |
|---|---|
| **Glaucoma** | **Yes ☐ No ☐** _____ |
| **Cataracts** | **Yes ☐ No ☐** _____ |
| **Macular Degeneration** | **Yes ☐ No ☐** _____ |
| **Eye Injury** | **Yes ☐ No ☐** _____ |

**Retinal Detachment/Disease** Yes ☐ No ☐ _____
**Other Diseases** Yes ☐ No ☐ _____
**Blindness** Yes ☐ No ☐ _____
**Crossed Eye/Lazy Eye** Yes ☐ No ☐ _____
**Diabetes** Yes ☐ No ☐ _____
**Cancer** Yes ☐ No ☐ _____
**Heart Disease** Yes ☐ No ☐ _____
**High Blood Pressure** Yes ☐ No ☐ _____
**Kidney Disease** Yes ☐ No ☐ _____
**Lupus** Yes ☐ No ☐ _____
**Thyroid Disease** Yes ☐ No ☐ _____

## 5) SOCIAL HISTORY

**Do you drive?** Yes ☐ No ☐
**Any visual difficulties?** Yes ☐ No ☐
**If *yes* please explain**_____
**Do you use tobacco/e-cigarette?** Yes ☐ No ☐ **If *yes*, what type/ amount/ how long?** _____
**Do you use illegal drugs** Yes ☐ No ☐ **If *yes*, what type/ amount/ how long?** _____
**Do you drink alcohol?** Yes ☐ No ☐ **If *yes*, how often?**_____
**Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV?** Yes ☐ No ☐

## 6) REVIEW OF SYMPTOMS (Do you currently have the following):

**CONSTITUTIONAL**
- **Fever** Yes ☐ No ☐
- **Weight Loss** Yes ☐ No ☐
- **Weight Gain** Yes ☐ No ☐

**CARDIOVASCULAR/VASCULAR**
- **Heart Condition** Yes ☐ No ☐
- **High Blood Pressure** Yes ☐ No ☐
- **Vascular Disease** Yes ☐ No ☐

**EAR, NOSE, MOUTH, THROAT**
- **Allergies/ Hay Fever** Yes ☐ No ☐
- **Chronic Cough** Yes ☐ No ☐
- **Dry Mouth** Yes ☐ No ☐
- **Ear Infection** Yes ☐ No ☐
- **Sinus Congestion** Yes ☐ No ☐

**RESPIRATORY**
- **Asthma** Yes ☐ No ☐
- **Bronchitis** Yes ☐ No ☐
- **Emphysema** Yes ☐ No ☐

**GASTROINTESTIONAL**
- **Constipation** Yes ☐ No ☐
- **Diarrhea** Yes ☐ No ☐

**GENITOURINARY**
- **Bladder** Yes ☐ No ☐
- **Kidney** Yes ☐ No ☐

**MUSCULOSKELETAL**
- **Arthritis/Rheumatoid** Yes ☐ No ☐
- **Osteoarthritis** Yes ☐ No ☐
- **Muscle/Joint Pain** Yes ☐ No ☐

**INTEGUMENTARY (Skin)**
- **PXE (Pseudoxanthoma Elasti)** Yes ☐ No ☐

**NEUROLOGICAL**
- **Headache** Yes ☐ No ☐
- **Migraine** Yes ☐ No ☐
- **Seizures** Yes ☐ No ☐

**PSYCHIATRIC** Yes ☐ No ☐

**ENDOCRINE**
- **Diabetes** Yes ☐ No ☐

**If *yes*, your most recent blood sugar level?** _____
- **Thyroid/ Other Glands** Yes ☐ No ☐

**HEMATOLOGIC/LYMPHATIC**
- **Anemia** Yes ☐ No ☐
- **Bleeding Problems** Yes ☐ No ☐

**IMMUNOLOGY**
- **Syphilis** Yes ☐ No ☐
- **Hepatitis** Yes ☐ No ☐

**ALLERGIES** Yes ☐ No ☐

☐ **Medical Eye Exam to detect/rule out ocular and retinal diseases is recommended on annual basis through dilated fundus exam (DFE), photos, visual field testings (VF) or OCT scan. These elective services might not be covered/partially covered by your medical insurance.**

☐ **Reschedule to a later date** **Consent for** ☐ **DFE** ☐ **VF** ☐ **Photos** ☐ **OCT Scan** ☐ **Medical Eye Exam**

**Patient/Guardian Signature:**_____ **Date:** _____/_____/_____

Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care
Optometrist & Podiatrist

7406 N. La Cholla Blvd. Tucson, Arizona 85741
p: (520) 545-0202 f: (520) 545-0201
www.headtotoehealthcare.org

## Contact Lens Policy

Warning: If you are having any unexplained eye discomfort, watering, vision change/or redness, remove your lenses immediately and consult your eye care practitioner before wearing your lenses again.

Contact lens trials that are dispensed REQUIRE a contact lens follow-up before contact lens prescription can be finalized; unless it has been verified that patient has been wearing the same contact lens previously. Patient needs to have the contact lens in for a minimum of 2 hours before the appointment to ensure proper contact lens follow-up evaluation. This follow-up needs to be WITHIN 30 DAYS of the initial contact lens dispensed. AFTER 30 DAYS, patient will be responsible for an office visit fee.

It is considered another contact lens fitting if any changes requested be made to a FINALIZED H2T contact lens Rx. (Changing brands or colors)

If contact lens supply is ordered through H2T office, exchanges are only granted to UNOPENED and UNMARKED boxes.

## Glasses/ Frame Policy

ANY H2T prescription sunglasses or glasses will have a 30 DAYS adaptation period. WITHIN 30 DAYS OF THE EXAM DATE, patient is responsible for scheduling a glasses follow-up appointment if he/she is having problems with their prescription. AFTER the 30 DAYS, there will be an office visit fee for a prescription recheck. There will be a charge for verification of glasses purchases elsewhere with H2T prescription.

NO RETURNS are granted once a purchase is made. There are NO EXCHANGES for any purchased non-prescription glasses, sunglasses or accessories.

H2T is not responsible for any scratched, chipped or broken frame that is not considered a manufacturer defect. Lenses or frames will be sent out for verification. There will be a fee to have the lenses or frames replaced.

If patient prefers to provide a frame and have H2T fit lenses to the frame, H2T is NOT RESPONSIBLE for any damages to the frame. $40 Co-pay applies if patient chooses to used own frame.

H2T is not liable for any frame adjustments that is not purchased through H2T. This is a PAID service and H2T are NOT LIABLE for any damages or scratches that could happen during this service.

## No Show/ Cancellation/ Medical Records Policy

ALL scheduled no show appointments will be charged $50.00 no show fee. Patient is responsible to CALL the office to reschedule or cancel any appointment at least 24 hours in advance. There will be a $15 fee for medical record per request.

## H2T Office Policy

Photo ID required for insurance and physical address verification. Vision or Medical cards are required at the time of service for continuation of care. Patient is responsible to notify H2T any insurance changes. Any unverified insurance information will result in the visit being a self-pay visit.

H2T utilizes electronic communications either through email or text messaging. Patient has the option to opt-out of these communications at anytime by following the instructions on the electronic communications received.

H2T DOES **NOT** participate with any workman's compensation companies.

I, _____, have read, understand and acknowledge the office policies stated above including our COVID-19 protocol.

Signature_____ Date: _____

Effective May 2020

Patient Name:_____ DOB:_____/_____/_____

# Antioxidant Screening: What's your Number?

Dear Patient,

We are committed to improving your health and the best approach is to be proactive. We know that consumption of certain vitamins and carotenoid antioxidants:

- Helps to promote **wound healing**
- Decrease risk of **diabetic complications**
- Decreases **inflammation**
- Improves **nerve function and circulation**
- Helps with **Fungal Infections**
- Maintains good eye health
- Decreases risk of **macular degeneration**
- Decreases risk of **glaucoma**

There is also strong evidence that abundant carotenoid antioxidants can:

- Slows the aging process
- Improves immune function
- Decreases risk of cancer
- Decreases risk of heart disease
- Improves skin, hair, and nail health

Yale University and the Dr. OZ Show recently discussed the importance of abundant antioxidant levels. Our practice has invested in a technology that is more accurate than blood tests and allows you to receive a non-invasive measurement of your carotenoids antioxidant levels. We can easily monitor your levels on a routine basis so you can work on improving your score with proper nutraceuticals, diet, and lifestyle. **The scanner will tell you if your vitamins are working or not.**

If you would like this service, a $30 fee will be added to your office visit, which includes your follow-up scan. We will rescan you in 60 days to see how you improve. This is a relatively easy number to improve within a couple of months

Please initial one, Thank you.

_____Accept
_____Decline
_____To be discussed

To your health,
Dr. Alan Shih
Dr. Zuraida Zainalabidin