

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.

Health 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.



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 filing a complaint.

Effective Date of this Notice: September 21, 2013



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, filing 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 <input type="checkbox"/> No <input type="checkbox"/>	Foreign Body Sensation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Burning	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glare/ Light sensitivity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye/ Lid Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Itching	Yes <input type="checkbox"/> No <input type="checkbox"/>
Distorted Vision/ Halos	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of Side Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Double Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dryness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mucous Discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excess Tearing/ Watering	Yes <input type="checkbox"/> No <input type="checkbox"/>	Redness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Pain/ Soreness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sandy/ Gritty Feeling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Flashes/ Floaters in Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tired Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

2) OCULAR CONDITIONS

Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blindness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Crossed Eyes/Strabismus	Yes <input type="checkbox"/> No <input type="checkbox"/>
Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lazy Eye/Amblyopia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetic Retinopathy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retinal Disease/Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dry Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Ocular Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Refractive Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	How old is your present pair?	_____
Do you wear glasses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	How old is your current pair?	_____
Do you wear contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you sleep in them?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What type of contact lenses?	Hard <input type="checkbox"/> Soft <input type="checkbox"/>	How often do you change/dispose of your CL?	_____
Are they comfortable?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Interested in refractive surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

4) FAMILY HISTORY

Disease/ Condition:	If yes, please indicate which relative; specify maternal or paternal if necessary	
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Eye Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Retinal Detachment/Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Other Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Blindness	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Crossed Eye/Lazy Eye	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Lupus	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

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		MUSCULOSKELETAL	
Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis/Rheumatoid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoarthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Gain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle/Joint Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
CARDIOVASCULAR/VASCULAR		INTEGUMENTARY (Skin)	
Heart Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	PXE (Pseudoxanthoma Elasti)	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	NEUROLOGICAL	
Vascular Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>
EAR, NOSE, MOUTH, THROAT		Migraine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies/ Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	PSYCHIATRIC	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dry Mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	ENDOCRINE	
Ear Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sinus Congestion	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, your most recent blood sugar level? _____	
RESPIRATORY		Thyroid/ Other Glands	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC	
Bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bleeding Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
GASTROINTESTINAL		IMMUNOLOGY	
Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Syphilis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
GENITOURINARY		ALLERGIES	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bladder	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Kidney	Yes <input type="checkbox"/> No <input type="checkbox"/>		

☐ 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: ____/____/____

Contact Lens Policy

Warning: If you have 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, the 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-DAY adaptation period. WITHIN 30 DAYS OF THE EXAM DATE, the 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 a patient prefers to provide a frame and have H2T fit lenses to the frame, H2T is NOT RESPONSIBLE for any damage to the frame. \$45 Co-pay applies if patient chooses to use own frame.

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

No Show/ Cancellation/ Reservation Fee/ Medical Records Policy/ Collection

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 48 hours in advance. There will be a \$15 fee for medical record per request. If your account is delinquent and H2T transfers it to the collection agency, \$35 will be assessed to your delinquent account. H2T will collect reservation fee when scheduling appointments.

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 of 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 pandemic protocol.

Signature _____

Date: _____

Effective Jan 2024

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