

Dear Patient,

Thank you for allowing us to provide your vision care. Attached is a patient information form, information on our latest technology, as well as our privacy practices notice. We ask you to fill these out and bring them along with you to your visit. If you wear glasses or contact lenses, please bring them with you. If you are wearing disposable contact lenses that we did not prescribe for you, please bring along a container for each lens that shows the lens information.

We are located in Bristol Park, which is a professional office park directly behind the Hunter's Crossing Publix shopping center. If you are heading north on NW 43rd Street, turn left at the light by the McDonald's and M&S bank as if you were going into the shopping center. Continue straight back behind the shopping center and you will see a sign for Bristol Park. Stay to your left and we are in building #4635.

We almost always see our patients on time, and appreciate your promptness.

If circumstances arise that you need to change your appointment time, please give us as much notice as possible to allow someone else to take your spot, 24 hours at least, please.

Fees, including any co-payments, are due at the time of your visit. We do accept cash, checks, visa, mastercard, american express, discover, and debit cards. We also offer Care Credit which is a health care expense only credit card, that you may apply for and use in our office as well as many other health care offices.

Please bring both your vision plan information as well as your major medical insurance information. We may be able to submit your visit (if there is a medical reason) to your medical insurance for you.

We look forward to your visit and helping you with your vision care needs.

Best regards,

Dr. Heather Starling and Staff



Name _____ Date _____
(First) (MI) (Last)

Address _____ Apt _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Home phone _____ Cell phone _____

You or your parent's employer _____ Occupation _____

Spouse or Parent's name _____ Work phone _____

If you are a student, name of school _____

E-mail address _____

How did you hear about our office? Another patient Yellow Pages Insurance

If referred by another patient, please list their name, so we may thank them _____

Date of last eye exam _____ Doctor _____

In the past 7-10 days have you experienced any of the following? (please check all that apply)

- Loss of vision
- Double vision
- Mattering
- Excessive light sensitivity
- Tearing
- Floaters
- Burning
- Blurry vision
- Redness
- Headache
- Itching
- Flashing lights

Personal Health History (please check all that apply):

Constitution:

- Developmental disability
- Cancer
- Fatigue Syndrome

ENT:

- Hearing Loss
- Dry mouth
- Sinusitis
- Laryngitis

Neurological:

- Cerebral Palsy
- Multiple Sclerosis
- Tumor
- Epilepsy

Psychological:

- Depression
- Other

Cardiovascular:

- Heart disease
- Stroke
- Vascular disease
- Congestive heart failure
- High blood pressure

Respiratory:

- Emphysema
- Smoker
- COPD
- Bronchitis

GI:

- Chron's disease
- Ulcer
- Colitis

Genito-urinary:

- Kidney
- STD (herpes/Chlamydia)
- Prostate disease/cancer

Musculo-skeletal:

- Muscular dystrophy
- Osteoarthritis
- Fibromyalgia
- Ankylosing spondilitis
- Arthritis

Integumentary:

- Psoriasis
- Eczema
- Rosacea

Endocrine:

- Hormonal dysfunction
- Insulin dependent diabetes
- Thyroid dysfunction
- Non-insulin diabetes

Hematology/Lymphatic

- Ulcer
- Anemia
- High Cholesterol
- Large volume blood loss

Allergy/Immunology:

- Environmental
- Lupus
- Rheumatoid Arthritis



- Please list all current medications you are taking (including eyedrops):
- Do you currently take: (please check any that are applicable)
 Plaquenil Tamoxifen Accutane Herbal supplements
- Please list any allergies to medications:

Previous ocular history: (please check all that apply)

- Glaucoma Cataract Macular degeneration Injury
 Strabismus Patching Inflammatory disorder Surgery
 Glaucoma suspect Amblyopia Retinal hole/tear/detachment Other

Family history: (please check all that apply)

- High blood pressure Thyroid disease Diabetes Cancer

Family ocular history: (please check all that apply)

- Amblyopia Strabismus Glaucoma Severe Myopia
 Retinal detachment Severe Hyperopia Cataract Glaucoma suspect

- Do you smoke? (if yes, please indicate how many packs per day)
- Do you drink more than 4 alcoholic drinks per week?
- Are you currently pregnant?
- If you currently wear contact lenses please list the type of contact lenses you wear:
How often do you replace your lenses?
How many hours per day do you wear contact lenses?
What type of solution do you use?
Do you sleep in your contact lenses?
- Are you interested in getting new glasses at your visit today?
- Are you interested in getting a prescription for contact lenses at your visit today?
- Do you have any other concerns you would like addressed at your visit today?

Office Policies

- Patients under the age of 18 can not be examined unless accompanied by a parent or guardian.
- Eyeglass prescriptions will be rechecked as a courtesy for a period of 3 months at no charge. After this 3 month grace period expires, office charges will apply.
- All contact lens exams include 3 months of follow-up care. If lenses are not picked up within this time frame or follow-ups are not completed, a new exam will be required to release the prescription.
- In accordance with Florida Laws and Rules, section 59V-3.007, all patients will be tested for glaucoma as part of the routine exam. No exceptions will be made to this policy.
- Payment is due at the time services are rendered. You will be held financially responsible for any fees not covered by insurance programs. Professional fees are non-refundable.
- Insurance or discount programs must be presented at the time of service, or can not be accepted.
- By signing below, you authorize Starling Eye Group to submit insurance benefits on your behalf and release any medical information that may be necessary to process your claim. Once they are submitted, no adjustments may be made. Patients are responsible for understanding their insurance benefits.

Patient signature: _____
(or parent if patient is under the age of 18)

Retinal Screening Wellness Examination

In our continued efforts to bring the most advanced technology available to our patients, Starling Eye Group is proud to announce the inclusion of the RTA as an integral part of your eye examination today. The RTA takes an image of the retina and also uses a scanning laser to analyze the retina layer by layer. It compares your individual data to age-related normals as well as takes into consideration your ethnic background.

The RTA wellness exam will provide you with:

- An eye wellness exam scanning from the macula to the optic nerve
- An in depth view of the different layers of the retina (where disease can start)
- An annual, permanent record for your medical file, which gives Dr. Starling the ability to compare your images and data from year to year and diagnose potential eye disease.

The RTA is fast, easy, and comfortable. It does not require dilating your eyes or instilling eye drops. Dr. Starling prescribes the RTA Wellness exam for all patients. This is especially important for those with a **history of retinal problems, diabetics, patients with high pressures, as well as those with a family history of glaucoma or macular disease.** We will perform the RTA wellness exam as an enhancement to the general eye exam for \$39.00. Some vision plans do cover this procedure.

_____ Yes, I would like to have the RTA wellness exam today.

_____ I would like more information regarding the RTA wellness exam.

Starling Eye Group 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.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

- This notice describes the practices of our employees and staff.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, phone number, and e-mail address.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" - such as the referring physician, your other doctors, your health plan, and close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

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For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.

Public Policy Uses and Disclosures. There are a number of public policy reasons why we may disclose information about you which are described below.

We may disclose health information about you when we are required to do so by federal, state, or local law.

We may disclose protected health information about you in connection with certain public health reporting activities.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury or disability, or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and Health Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to a communicable disease or to an employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorizes the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies that are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or 4)

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entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including in response to a warrant, subpoena, or other order of a court or administrative hearing body or to assist law enforcement identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes also permit use to make disclosures about victims of crimes and the death of an individual, among others.

We may release a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors. We also may release your health information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.

We may release your health information to workers' compensation or similar programs, which provide benefits for work-related injuries or illnesses without regard to fault.

Health information about you also may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain health information about your condition and treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol and for other research purposes.

If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We also may release health information about foreign military personnel to their appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health or safety, or the health or safety of others.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information

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to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" -- such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. Additionally, we may contact you to follow-up on treatment options or services. These communications may include, but are not limited to, postcards, letters, telephone reminders, or e-mail reminders, unless you choose not to receive such reminders.

Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

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If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.

You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make and uses and disclosures before April 14, 2003, among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have the right to a copy of this notice in paper form. You may ask us for a copy at any time.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C., 20201 (e-mail: ocrmail@hhs.gov).

Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____