

**CENTER FOR
RETINA AND
MACULAR DISEASE**



Main Office
250 Avenue K, SW Suite 200
Winter Haven, FL 33880
863/297-5400
800/472-8867 Toll Free

Dear Patient:

Welcome to our office: Dr. Misch, Dr. Berger, Dr. Tolentino, Dr. Moon, Dr. Hamilton, Dr. Gehrs and Dr. Kim are physicians/ surgeons specializing in problems affecting the macula and retina (the back two-thirds of the eye). Dr. Misch established our first office in 1991. Dr. Braudway is also a part of our practice specializing in low vision care.

Enclosed is a prescription card for your personal use. Please write all of your medications on this card and carry it with you at all times. You do not need to turn this card in to our office.

Referrals: If you belong to a Health Maintenance Organization (HMO), you are responsible for bringing your referral with you at the time of your visit.

Co-pays and Coinsurances: We will be happy to file your insurance; however, please be aware of any co-payments and coinsurances that are due at the time services are rendered. If you have any questions as to what this may be, please contact your insurance carrier or check your insurance ID card. If you have no insurance or a medical plan with a high deductible we will be more than happy to set up payment arrangements for you. We will require that you pay a deposit at the time of service.

Items to bring with you: Please bring your health insurance cards, a list of your prescription medications, a photo identification card, and a driver with you at the time of your visit.

Appointment time: Your appointment allows time necessary for records processing, pupil dilation, and examination. Please plan to spend about 1 to 1 ½ hours with us during your visit, possibly longer if diagnostic studies or treatment are needed.

Pupil dilation: It will be necessary to dilate your pupils for retinal examination. This may result in blurred vision for the rest of the day (occasionally longer). Plan to bring a driver with you for your appointment, as it may not be safe for you to drive home. Babies take longer to dilate so the visit may be longer. Please bring necessary supplies for the long wait.

Visitors: Due to the length of your visit, limited waiting room space, and the fact that delicate procedures are being performed in the office, we ask that you bring only a driver.

Illness: If you are ill, we prefer that you reschedule your appointment so our other patients and staff are not exposed. We will be glad to reschedule your appointment on a priority basis as soon as you are feeling well.

Public transportation options:

Winter Haven: Imperial Cab – 968-9494
Lakeland: Rapid Transit – 648-1849 / Viste – 284-0828
Clermont: Lake County Transport – 352-360-6618
Sebring: Highlands Yellow Cab – 382-6119
Zephyrhills: Zephyr Cab – 813-782-7905 /
Pasco County Transportation – 352-521-4300
Haines City: Imperial Cab 968-9404

Thank You for your Consideration

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Patient Registration Sheet

Mr. Mrs. Miss. _____ Date: _____

Date of Birth: _____ Marital Status: _____ O S M D W

Social Security Number: _____ Sex: M F

Florida Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Emergency Contact Name: _____

Emergency Contact Number: _____ Relationship: _____

Secondary Mailing Address: (if applicable) _____

City: _____ State: _____ Zip Code: _____

If insurance is in name other than patient or if patient is a minor, please complete information below:

Guardian or Spouse Name: _____

Guardian or Spouse's Employer: _____

Work Number: _____ Home Number: _____

Guardian or Spouse's Date of Birth: _____

Social Security Number: ____ - ____ - _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

I authorize the release of payment for medical benefits to my physician. I authorize the release of any medical information necessary to process all claims.

Patient's Signature _____ Date: _____

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Date: _____

In case of medical emergency, I, _____
give permission to The Center for Retina and Macular
Disease to release my medical information and records to:

Name Relationship

Signature: _____



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Your Rights to Privacy

Vitreous and Retina Consultants, PA d/b/a Center for Retina and Macular Disease is committed to treating and using your protected health information in a responsible manner consistent with both state and federal regulations.

Every time you are seen by a physician at Center for Retina and Macular Disease, information about your visit is recorded in your medical record. The information contained in your medical record typically describes symptoms, diagnoses, test results and treatment plans as they relate to your medical condition. I agree that the physicians of Center for Retina and Macular Disease may periodically review my chart for additional programs that I may be eligible. Center for Retina and Macular Disease uses your health information when billing your insurance company or third party payer for medical services that were provided to you. We do not participate in any data banks or disclose health information other than what may be required by law. Your medical privacy is extremely important to us and as such, unless you authorize us in writing your medical information is confidential..

Your right to obtain a copy of your medical record is provided for in 45 CFP.164.522, 164.522, 164.524 and 164.528.

Signature on file

I request that payment of authorized insurance and/or Medicare benefits be made either to me or my balance to Vitreous and Retina Consultants, PA d/b/a Center for Retina and Macular Disease. I authorize the release of medical information needed to determine benefits and the benefits payable to related services. I understand that my signature authorizes the release of medical information necessary to pay the claim as well as requesting payment be made. I have received, read and understand your Notice of Privacy Practices.

Vitreous and Retina Consultants, PA d/b/a Center for Retina and Macular Disease agrees to accept the charge determination of the Medicare carrier and/or other insurance as the full charge. The patient is responsible for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance and/or Medicare carrier. *It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. It is also understood that a 1.5% finance charge will be applied to any account that is delinquent over 90 days. I will be responsible for any court and/or collection fees.* **I also understand that I have the right to revoke the authorization to use my health information – except to the extent that action has already been taken.**

Patient Name: _____ Relationship: _____

Signature: _____ Date: _____

Interpreted by: _____

Internal Use Only:

If patient or patient's representative refuse to sign acknowledgment of receipt of notice, please complete the below:

Date notice presented to patient: _____ Time presented: _____ Signature of Staff who presented: _____

PATIENT MEDICAL HISTORY

PATIENT MEDICAL HISTORY		
Do you or have you had.....		Please list your current Eye Drops below:
1. Heart Disease	Y or N	* L / R eye
2. Hypertension	Y or N	* L / R eye
3. Asthma	Y or N	* L / R eye
4. Stroke	Y or N	* L / R eye
5. Thyroid Disease	Y or N	* L / R eye
6. Diabetes	Y or N	
7. Arthritis	Y or N	List all Allergies below:
8. Cancer	Y or N	*
9. OTHER: (Please list below)		*
*		*
*		*
*		*
Past Eye Surgeries		Please list your current medications below:
1. Cataract		*
2. Corneal		*
3. Implants		*
4. OTHER: (Please list below)		*
*		*
*		
*		
Past Major Surgeries		
1. Pacemaker		
2. Pins/Rods		
3. OTHER: (Please list below)		
Patient Name: _____		
Patient SSN: _____		
Patient Date of Birth: _____		
Medical Record Number: _____		