CENTER FOR RETINA & MACULAR DISEASE

CELEBRATING 30 YEARS

DAVID M. MISCH, MD
ADAM S. BERGER, MD
SUK JIN MOON, MD
RICHARD S. HAMILTON, MD
JOHN C. RANDOLPH, MD
LOGAN L. CHRISTENSEN, MD
HERSHEL R. PATEL, MD
SONYA M. BRAUDWAY, OD

Welcome!

To the Center for Retina & Macular Disease

Welcome to our office: Dr. Misch, Dr. Berger, Dr. Moon, Dr. Hamilton and Dr. Randolph are physicians and 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.

Referrals: If you belong to a Health Maintenance Organization (HMO) or Medicare Replacement plan, please contact our office prior to your appointment to insure we have authorization for 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. 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. Thank you for your consideration.

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RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE CENTER FOR RETINA AND MACULAR DISEASE TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

CENTER FOR RETINA AND MACULAR DISEASE MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT CENTER FOR RETINA AND MACULAR DISEASE WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

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Patient Registration Form

Patient Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____ Email Address: _____

Social Security Number: _____ Sex: ☐ Male ☐ Female

Florida Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Emergency Contact Name: _____

Emergency Contact Number: _____ Relationship: _____

Secondary Mailing Address (if applicable): _____

City: _____ State: _____ Zip: _____

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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Patient Medical History

Patient Name: _____

Current or past medical problems

Heart Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Other: _____

_____

Please list any past major surgeries: _____

_____

Please list any past EYE surgeries such as cataract surgery, corneal surgery, retina surgery, implants, etc.	**Current EYE drops**	**Current medications** *or attach a list*
•	•	•
•	•	•
•	•	•
•	•	•
•	•	•
•	•	•
•	•	•
•	•	•
•	•	•
•	•	•

Please list ALL ALLERGIES: _____

_____

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Center for Retina and Macular Disease
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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

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- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer

Phone number: 863-297-5400

Fax number: 866-463-4799

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became

effective on **9/23/13**.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

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Office Locations
(800) 472-8867

Winter Haven
250 Avenue K, SW
Winter Haven, Florida 33880

Lakeland
2815 Lakeland Hills Blvd.
Lakeland, Florida 33805

Clermont
1655 E. Hwy. 50, Suite 204
Clermont, Florida 34711

Zephyrhills
6719 Gall Blvd., Suite 206
Zephyrhills, Florida 33540

Sebring
5233 US 27 North
Sebring, Florida 33870

Haines City
137 Patterson Road
Haines City, Florida 33844

The Villages
4636 Bellwether Lane
Wildwood, Florida 34785