PERSONAL EYECARE

Your Best Eyesight Is Our Focus

Patient Name: _____ (Print)

Optomap DIGITAL RETINAL IMAGING

Optomap Digital Retinal Imaging is technology that allows instant viewing of subtle changes in retinal health by combining retinal photography and computerized digital imaging. We can compare today's images with future images and carefully observe any abnormal changes. We believe this will promote earlier diagnosis of many eye diseases. ***Our doctors recommend Optomap for every patient every year to help detect retinal eye disease.*** Our fee for this procedure is **$44**.

I consent to the Optomap for myself/my child. ☐ **YES** ☐ **NO**

INFORMED CONSENT FOR DILATION OF EYES

In order to thoroughly examine the inside of the eye for signs of disease, we may need to place drops in your eyes, which dilate or enlarge your pupils. The side effects are temporarily blurred vision and light sensitivity for approximately 4-6 hours. We believe the benefits of having the eyes dilated extremely outweigh the disadvantages. This procedure is provided at no additional fee and takes approximately 20 – 30 additional minutes to complete the examination.

I consent to the dilation procedure for myself/my child. ☐ **YES** ☐ **NO**

Liability Release: I have been informed by Personal Eyecare and its staff of the importance of pupil dilation and Optomap retinal screening. If I have chosen not to have one or both of these tests performed, I will not hold Personal Eyecare and/or its stall responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained by these testing procedures.

Please sign to consent for the procedure (s) or to confirm abiding by the liability release form.

Guarantors signature: _____ Date: _____

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CONSENT FOR TREATMENT, PRIVACY NOTICE ACKNOWLEDGEMENT AND INSURANCE RELEASE

I hereby give consent to Personal Eyecare to provide whatever treatment they may deem necessary. I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy. I acknowledge I have read and understood the HIPAA Privacy policy, which outlines how my health information is utilized. I hereby request payment of authorized insurance benefits for me to be paid directly to Personal Eyecare for any services furnished to me by Personal Eyecare. I authorize Personal Eyecare to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me to determine these benefits or the benefits payable for related services. I understand this is a lifetime authorization.

Patient signature: _____

Guarantors signature: _____ Date: _____

Optional: : If it is necessary for someone other than yourself to discuss your medical conditions, bills or finances with Personal Eyecare, please provide the individual's name below to appoint and authorize them to act as your personal representative for this limited purpose. Should you decide to change this authorization you may contact us at any time.

_____	_____	_____
Name of Personal Representative	Relationship	Phone Number

CONTACT LENS ASSESSMENT FEES:

For both current contact lens wearers and also new contact lens wearers, there are separate fees charged in addition to your eye examination each year. The contact lens fee is generally not covered in full by your vision plan and must be paid for at the time of service. Our fees for contact lens services vary based on the complexity of your lens design and need for insertion/removal training, follow-ups or refitting. They range from simple annual contact lens prescription renewal ($55) up to specialty contact lens fittings ($299). I understand that I am liable for this fee as long as I choose to wear contact lenses.

Patient signature: _____

Guarantors signature: _____ Date: _____