

## **Dilation Consent Form**

Dilation of the pupils of your eyes is an important component of every comprehensive eye exam. It allows your doctor to detect many eye diseases, including glaucoma, macular degeneration, and cataracts. Additionally, illnesses such as high blood pressure and diabetes can be detected during a thorough evaluation of eye structures. The state of Florida has made it mandatory for eye doctors to dilate the pupils of all patients' eyes when medically necessary. Precautions should be taken with stops, stairs, and especially driving. These effects last for several hours.

Although we feel it is important to perform this test, if for some reason you wish to not have this done, you may defer this test until a later date. We will be willing to perform the dilated exam within one month of your original exam at no additional cost.

\_\_\_\_\_  
Yes, I wish to be dilated

\_\_\_\_\_  
No, I do not wish to be dilated

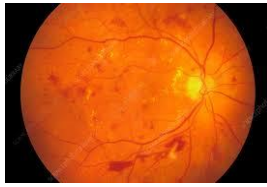
## **Computerized Visual Field Screening Test**

We have incorporated into our practice a computerized **Oculus Visual Field Analyzer** that measures retinal function, light sensations, and peripheral vision.

Unfortunately, routine eye exams do not detect many diseases in their early stages. However, this visual field computer can detect vision loss much like a "cat scan" especially for the eye. The visual field analyzer detects diseases that can affect vision such as pituitary tumors, glaucoma, macular degeneration, optic nerve disorders, and retinal disturbances due to medications, as well as others. We recommend that all of our patients receive this evaluation. An additional nominal fee of \$25.00 for the screening.

\_\_\_\_\_  
Yes, I would like the additional screening test

\_\_\_\_\_  
No, I understand the importance of this test, but wish to decline



## **ADVANCED iWELLNESS RETINAL EXAM**

We are excited to let you know that during your visit today you will experience the benefits of the latest advancement in eye healthcare, the Advanced iWellness Retinal Exam. Advanced iWellness uses breakthrough technology to let us see beneath the surface of your retina and allows our doctors to see signs of disease before they would be revealed with traditional examination methods. Advanced iWellness captures 80% of your retina in a digital image enhancing your doctor's ability to detect and monitor your eye health.

Many eye problems can develop without warning and progress without symptoms. In the early stages, you may not even notice a change in your vision. But sight threatening conditions and diseases such as macular degeneration, glaucoma, diabetic retinopathy and others can be detected thorough evaluation of the retina by combining an OCT scan and a Digital Retinal Imaging technology.

This exam offers a fast, simple procedure that can help your doctor provide you with early detection of ocular and systemic diseases such as:

- Diabetic Retinopathy (Damage to blood vessels in the retina)
- Glaucoma (Increased eye pressure)
- Age related Macular Degeneration (ARMD)
- Diabetic
- Hypertension

At our office, we are dedicated to providing our patients with the best eye health care possible and this exam allows us to do that. Typically, the cost of each scan is \$35, but as part of our wellness initiative we are offering our patients both scans for a nominal fee of \$49. Our doctors recommended updating your scans yearly as part of your comprehensive eye exam.

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Patient Signature

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Date

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Print Name

## **Signature on File Form**

### ***RESPONSIBILITY STATEMENT***

Your insurance is a method for you to receive reimbursement for the fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

### ***FINANCIAL RESPONSIBILITY***

By signing this statement, you agree to be financially responsible for all charges.

### ***AUTHORIZATION TO RELEASE MEDICAL INFORMATION***

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_