revolutionEYES

All patients should receive a comprehensive health evaluation annually. We believe that even patients with a health eye should be screened annually in order for the doctor to be able to compare the baseline image of the healthy eye with any future images that may detect disease. The doctor is able to get a much better view of the inside of the eye, resulting in a more thorough eye examination. There are many conditions that can only be detected with a health evaluation, such as macular degeneration, glaucoma, and diabetic complications. There are two options that allow us to check the health of your eyes.

Retinal Photo: This option will have a fee of $29. This procedure takes less than 3 minutes. There are no lasting side effects. This provides a permanent record of your retinal image. Knowing what the eye looked like when it was healthy is often the best way to detect if disease is starting. Your retinal photo can be compared with future photos to determine if any changes have occurred.

Dilation: With dilation, eye drops are used to make your pupils larger. This procedure adds approximately 30 minutes to your exam. The effects of the drops usually last 5-6 hours, and cause blurred near vision. You will be sensitive to bright lights. If you do not have a pair of sunglasses we will provide a disposable pair. The most common reasons for a dilated exam include: small pupils, trauma, lens opacities (cataracts), and symptoms such as floaters or flashes of light. A dilated exam is recommended for anyone who has never been dilated before. Some people find driving difficult after dilation. If you feel unsure or uncomfortable, we recommend that you have someone else drive you.

Please initial one of the following:
I have read and understand the above information.

_____ I chose to have my retinal health evaluated with photos.

_____ I chose to have my eyes dilated in place of photos. I am aware of the side effects of the drops and the additional time that will be added to my exam.

_____ I decline both the photos and the dilation. I understand that by refusing these procedures a sight threatening condition may exist that cannot be detected.

By my signature below, I consent to examination and treatment necessary for the care of the patient. I hereby authorize the release and transfer of any information required, in accordance with HIPPA privacy regulations.

- I accept financial responsibility for all charges incurred, and acknowledge that payment is due at the time of service. I understand that the submission of an insurance claim is not a guarantee of payment to the provider. If the insurance claim is denied or does not pay in full, I accept the financial responsibility for the balance. I understand that if my account is sent to collections there will be a 40% fee added.
- Contact lens prescriptions may be released once the doctor is satisfied with your lens fit and compliance. This, however, releases this office from any other responsibility with respect to your contact lens care.
- I understand that I have 30 days from the original exam date to return for a recheck at no additional charge (excludes diabetic changes and contact lens overwear.) After 30 days I will be responsible for a $29 fee, this applies up to 6 months from the original exam date.

I hereby certify that I have read and fully understand the statements above.

Patient Signature (parent or guardian if under 18) Date