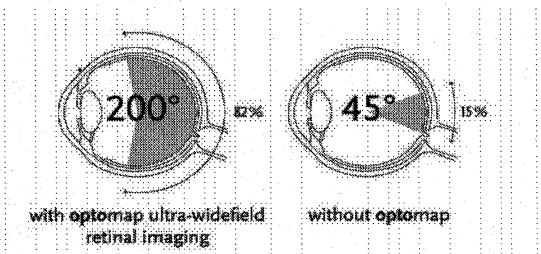
EYE HEALTH ASSESSMENT (V030220)

As part of your Comprehensive Eye Examination,There are **TWO** ways that our doctors can more thoroughly assess the health of your eyes.

1) OPTOMAP Retinal Exam AND OPTOVUE iWellness Scan.

- Your Vision plan covers these screens with a **$39 copay**. We believe it is an integral part of your annual examination to assess the health of your eyes. (Children 17 and under have a **$25** co-payment for Optomap ONLY)
- These painless and non-invasive screenings provide the doctor with a detailed view of the back of the eyes without the use of dilating drops.
- This information can help in the early detection of common eye diseases such as diabetic retinopathy, glaucoma and macular degeneration.
- These images and scans become part of your permanent medical file, enabling your doctor to make important comparisons should threatening conditions manifest in future examinations.
- In certain cases, the doctor may elect to dilate the eyes after viewing the images and scans to further assess any areas of concern.
- **Diabetic patients who are not monitored yearly by other eye care professionals outside this office may require both a dilation as well as an Optomap and iWellness scan.**



2) Dilated Retinal Examination (with doctors discretion)

- After instilling the dilating drops in the eyes, the pupils will enlarge after several minutes.
- This gives the doctor the ability to do a more complete assessment of the back of the eyes, although the doctor may defer the dilation due to individual patient circumstances.
- The drops will cause some blurriness and light sensitivity for approximately 3 (three) hours.
- We will provide you with disposable sunglasses that will reduce the light sensitivity and allow you to drive and be outdoors.
- The doctor may recommend to reschedule or defer the dilation for a later date depending on circumstances during your examination.

3) You can elect to have NEITHER **Dilation** nor the **Optomap Retinal Examination and iWellness Scan** performed today

- By Selecting this option, you may be limiting the doctors ability to detect certain eye diseases early which can lead to future vision loss. The doctors may still require to dilate the eyes based on your exam findings or medical history.

*****I elect to have my eye health assess by Method # _____ (1, 2 or 3)*****

_____ _____

Patient / Guardian Signature Date

PAYMENT, INSURANCE AUTHORIZATION & HIPAA PRIVACY ACKNOWLEDGEMENT

I have received and understand the practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information (PHI) that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my PHI.

I understand that this practice reserves the right to change these terms of its Notice of Privacy Practices, and to make changes regarding all PHI resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide my revised Notice of Privacy Practices upon my request.

❑ **YES, I UNDERSTAND** (if you would like a hard copy of the HIPAA to keep, please ask)

I hereby give authorization for payment of Medicare and/ or any other insurance benefits (if applicable) to be made directly to Bonita Point Family Optometry, Inc. for services and materials rendered. I also authorize the release of any medical or demographic information necessary to secure payment of benefits. I understand I am responsible for all co-pays, deductibles, co-insurance and charges not covered or denied by the insurance company.

❑ **YES:** I have read and agree to above

❑ **NO: I DO NOT** have insurance and will pay privately.

Contact Lens Evaluation and / or Fitting Notification

The Comprehensive eye examination DOES NOT include a contact lens evaluation and / or fitting, or contact lens follow up. There is an additional fee for any services related to contact lenses above and beyond the comprehensive eye exam charges. Your insurance may or may not have coverage for the contact lens evaluation and / or materials.

❑ **YES: I want a Contact Lens Examination** and understand there is an additional fee for contact lens related services and agree to a contact lens evaluation, fitting and / or contact lens follow up.

❑ **NO: I DO NOT** want to have any contact lens services performed at this time.

SIGNATURE/GUARDIAN SIGNATURE _____ PRINT NAME _____ DATE _____