Patient Name: _____

Retinal Exam Consent

An important part of your eye exam is the retinal evaluation. It allows Dr. Jana to evaluate your overall health by looking at blood vessels, nerves, and other components of the retina. Dr. Jana recommends the Optomap retinal photography technology to accomplish this. This imaging technology allows early detection of retinal disorders, including but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment. By performing this test, dilation is usually not necessary. This procedure is generally a non-covered service unless being used to actively follow ocular disease.

❒ I would like Optomap retinal imaging. I agree to the $39 fee for service not covered by my insurance.

❒ I prefer dilation drops and understand it will cause light sensitivity and blurred vision for 4-6 hours.

❒ I decline both Optomap and dilation. I understand that a comprehensive exam has not been performed and that retinal issues may not be detected.

_____ **Consent for Care:** I hereby give consent for treatment to Berry Farms EyeCare.

_____ **Authorization to Leave Message:** I authorize Berry Farms EyeCare to leave messages for me.

_____ **Cancellation/Refund Policy:** Cancellation within 30 days of order: Material fees minus 30% will be refunded to patient. Cancellation past 30 days of order: Material fees minus 50% will be refunded to patient.

_____ **Photography Release:** I hereby authorize the use of images on Berry Farms EyeCare media pages.

_____ **Contact Lenses:** Successful contact lens wear requires careful inspection of your contacts as well as an evaluation of the fit and prescription. To ensure proper eye health and performance, additional testing and evaluation are necessary and an additional annual fee starting at $80 will be applied to your normal eye exam. Exact fees are based on case complexity.

_____ **Medical Insurance vs. Vision Plan:** If you have separate Vision insurance, this generally pays for one annual routine eye exam and contributes a certain amount of money toward glasses or contact lenses. Vision coverage does not cover any exam which involves medical diagnoses. Your Medical insurance will be billed for the medical portion of your exam. You may then use your Vision coverage for materials purchased.

_____ **Refraction:** During a comprehensive eye exam, our doctor usually determines the prescription required for your eyeglasses or contact lenses. For patients with medical and eye health diagnoses, this procedure is often a necessary test which is performed and insurance companies require us to bill this separately. The charge for this necessary test is $25.

_____ **Dilation:** Following dilation, side effects can include: light sensitivity, difficulty focusing, increased glare, and driving difficulties. If you choose to be dilated, you assume the risk of the possible side effects and will not hold Berry Farms EyeCare, its doctors, or associates liable.

HIPAA Privacy Policy: Under the "Health Insurance Portability and Accountability Act" you have certain rights to privacy regarding your protected health information. You are free to refer to the Notice of Privacy Practices before you sign this form. As described in the Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination, of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment practices change. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have either received or have access to the Notice of Privacy Practices Berry Farms EyeCare PLLC.

STATEMENT OF FINANCIAL POLICY: It is customary to pay for all services and materials at the time of your visit, unless prior arrangements have been made. This includes co-pays, deductibles, and any cost not covered by insurance. While it is your responsibility, we will prepare any necessary forms to help you obtain your benefits from your insurance company. I understand that I am responsible for any costs not paid by my insurance. I do hereby acknowledge and agree that if my account becomes delinquent and requires the service of a collection agency or attorney, I will pay reasonable collection fees, attorney fees, and all court costs for said collection. I have read and understand all of the above.

Signature of Responsible Party: _____ **Date:** _____