DILATED FUNDUS EXAMINATION INFORMED CONSENT

DILATION OF THE PUPIL is required to be performed on all new patients during the initial visit to this office. Eye drops are used to enlarge the pupils. This allows the doctor to check for cataracts, glaucoma, retinal tears and other conditions that may result in loss of vision. Your vision for driving and especially reading may become blurry, and make your eyes sensitive to light for about 4-5 hours. Disposable sunglasses are available upon request. There is no additional fee for this test.

Please check (✓) one:

_____ **I DO** want to have my eyes dilated at this time and understand my vision may be impaired.

_____ **I DO NOT** want to have my eyes dilated at this time because ________________________. I understand that I am releasing Eye & Ear from any liability by not having the exam.

_____ **I WILL RESCHEDULE** an appointment for the dilation at a future date.

VISUAL FIELD SCREENING INFORMED CONSENT

Our office recommends a new **Computerized Visual Field Screening** every year to all of our patients. This test can aid in the early detection of the following problems: MACULAR DEGENERATION, BRAIN TUMORS, DIABETIC CHANGES, GLAUCOMA, MULTIPLE SCLEROSIS, and RETINAL DETACHMENT. IT IS ESPECIALLY IMPORTANT IF YOU HAVE BEEN HAVING **HEADACHES,** OR HAVE FAMILY MEMBERS WITH ANY OF THE ABOVE PROBLEMS.
THERE IS A NOMINAL FEE OF $10 FOR THIS TEST.

Please check (✓) one:

_____ **I DO** want to take this test at this time _____ **I DO NOT** want to take this test at this time

DIGITAL RETINAL IMAGING INFORMED CONSENT

Our office recommends a new state-of-the-art diagnostic procedure called ***Digital Retinal Imaging***. This procedure consists of capturing an image of the inside (retina) of your eye using a specialized digital camera. This is not an X-ray and nothing will touch your eye. This procedure can aid in the early detection as well as following eye problems such as DIABETIC RETINOPATHY, MACULAR DEGENERATION, GLAUCOMA, PRECANCEROUS LESIONS AND RETINAL BREAKS.
THERE IS A NOMINAL FEE OF $25 FOR THIS TEST.

Please check (✓) one:

_____ **I DO** want to take this test at this time _____ **I DO NOT** want to take this test at this time

I, ______________________________ ______________________________ ______________________
Patient's name (please print) **Patient's / Parent's Signature** **Date**

hereby acknowledge receipt of Eye & Ear's Notice of Privacy Practices given to me. In addition, I authorize this office to release any information needed to expedite insurance claims. I understand that I am responsible for all charges not covered by my vision insurance.