

DILATION INFORMED CONSENT

Dilation is recommended every year even in healthy eyes because it provides a better eye health evaluation. It may be required by the eye doctor in order to diagnose many ocular and systemic conditions. Many serious and sometimes vision-threatening conditions cannot be diagnosed or detected without dilation. Dilation is not necessary to determine a glasses or contact lens prescription. Because dilation can cause blurriness or light sensitivity for an average of between 4-6 hours, we recommend you have a driver with you. We can provide you with disposable sunglasses when your eye exam is finished. There is no additional fee for dilation provided you choose to be dilated the day of your comprehensive exam. If you elect not to be dilated on the day of your exam and need to return for a dilation appointment on another day, an office visit fee will be charged.

Do you wish to be dilated today? Yes No Need to discuss with doctor _____

HIPAA PRIVACY

I acknowledge and agree that I have been informed that this office abides by the HIPAA laws and I am entitled to a copy of the Notice of Privacy Practices for review and if desired, to keep for my records on the date identified below. I understand that the Office may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or types of products provided) to another party to permit the Office to perform its administrative duties, provide me with eye care services and products, process my vision/ medical benefits claims and communicate with me regarding vision care services/products provided by the Office (for example, mailings of exam reminders or information about services/products provided by the Office).

I can be assured that this Office does not sell my personal information of any kind to a third party for such party's own use. I authorize the Office to submit my vision/medical benefits claims to my plan sponsor or health plan to receive reimbursement directly for the vision/medical services and products that I have received from the Office.

Patient Signature or Patient's Legal Representative

Date

INSURANCE

Vision insurance plans our Office accepts: VSP

Medical Plans our Office accepts: None

As a courtesy, Lynette Devine, O.D., will bill your primary insurance carrier for you, provide it is one of the accepted insurances listed above and benefits can be verified prior to your exam. Please remember that you are ultimately responsible for payment of all services rendered. If your insurance assigns a copay for your care, we will collect the copay amount. In the event that your insurance denies your claim or applies your claim to your deductible or coinsurance, you will be responsible for the balance due and we will bill you accordingly.

I authorize the release of any information required to process an insurance claim. I understand that I am responsible for payment of any amount not covered by my insurance plan. By signing below, I submit all health information disclosed is accurate. I authorize the Office to receive insurance payments directly for the services I have received.

Patient Signature or Patient's Legal Representative

Date