Specs Eye Care
Consent for Testing and Dilation

Patient's Name____ Date___________________________

Vision threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy or changes from high blood pressure or high cholesterol often have no outward signs/symptoms. At Specs Eye Care, our doctors are using state-of-the-art technology to detect diseases in their earliest stages, when they are most treatable.

If you are here for a routine exam, our doctors strongly recommend the Optomap® Retinal Exam on ALL patients and Wellness OCT on all patients over 30. These quick, non-invasive procedures enhance your eye exam and allow the doctor to see a much broader and more detailed view of the retina compared to undilated (and in some cases, dilated) examinations. The scans become a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions present at a future examination. If you have high blood pressure, diabetes, high cholesterol or have a family history of any eye diseases, the doctor also recommends doing an AngioWellness screening to assess blood flow to your retinas.

The fee is **not** covered by your vision care plan or health care plan unless they reveal a problem with the health of your retina. If a health problem exists, your medical insurance will be filed as a courtesy for the testing. The fee for Optomap & Wellness OCT is only **$64** ($44 for optos, $20 for OCT). The fee for the Optomap, Wellness OCT & Angio Wellness OCT is only **$79.**

***Without either the Optomap or dilation of the pupils, your eye doctor may be unable to detect some health problems such as glaucoma, cataracts, retinal detachments or tears, diabetes, high blood pressure and some tumors. The only way to have a complete and thorough eye exam is to examine the retinas.**

Please INITIAL beside your choice:

___________ **Optomap and Wellness OCT**.* Recommended for ALL routine exams annually

___________I would like you to perform the **Optomap, Wellness OCT & AngioWellness OCT** *Recommended for patients with diabetes, high blood pressure, high cholesterol, and/or any family history of glaucoma or macular degeneration

___________ I prefer to have my eyes dilated today. I understand the risks/potential **side effects** of the dilation, including **blurry vision and light sensitivity**. I have a driver with me or will arrange for one at the conclusion of the exam if I feel I am unable to drive safely. A dilated fundus exam is included with the comprehensive eye exam at no additional charge.

Patient's/Guardian's Signature: ____Date:____________________

Specs Eye Care

PAYMENT & INSURANCE POLICY, CONSENT & HIPAA

Patient Name: ____ Date:__________________

Current Address: ____

PAYMENT POLICY/ASSIGNMENT OF BENEFITS to FILE INSURANCE/RELEASE OF INFORMATION:

*I hereby authorize payment directly to SPECS Eye Care. All Self-Pay or Insurance Co-Pay, including non-covered services, are due at the time of service. I understand that I am responsible for all charges not covered by my insurance. Self-Pay discount is not allowed for services billed to my insurance carrier. I hereby authorize release of all information necessary to pay my claim. There is a **$50** insufficient funds fee for all returned checks. There will be additional fees for any past due balances that are transferred to a collection agency.

Insured/Parent/Guardian Signature: ____ Date: ____________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

*I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Insured/Parent/Guardian Signature: _____________________________________ Date: ______________

*Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? (Circle one) YES NO Name of person:____

ROUTINE VISION PLAN vs. MEDICAL INSURANCE

There are **two types** of health insurance that will help pay for your eye health services and products. You may have both types and Specs Eye Care accepts most vision care plans and insurance plans in both categories: (1) **Routine** Vision plans (such as VSP, EyeMed) and (2) **Medical** insurance (such as Blue Cross/Blue Shield, United Health Care, Medicare and others).

• Vision Plans cover **ONLY** routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Routine Vision plans do **NOT** provide for MEDICAL EYE HEALTH CARE NEEDS (such as diabetes, dry eye disease, infections, floaters, etc)

• Medical Insurance **MUST** be submitted for any medical eye healthcare diagnoses and treatment care and follow-up per national billing guidelines

• If you have both Routine Vision Care benefits and Medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called “Coordination of Benefits” to do this properly and to maximize your best advantage and least cost to you.

• Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract.

Please provide both your routine vision plan provider and medical insurance card(s) and identification to our staff so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

By signing below, I acknowledge that I fully understand the difference between Routine vs. Medical Insurance:

Insured/Parent/Guardian Signature: ______________________________________ Date: ______________