

DILATION CONSENT INFORMATION

Dilation of the pupils of your eyes is an important component of every comprehensive eye exam. The purpose of a dilated fundus exam is to make the pupils larger so as to enhance the detection of any ocular pathology such as cataracts, glaucoma, macular degeneration, retinal detachments, malignant growths, retinal hemorrhages, etc. Additionally, illnesses such as high blood pressure and diabetes can be detected during a thorough evaluation of eye structures. Having your pupils dilated is a relatively painless procedure. It should be noted, however, that there are some minor side effects associated with having your pupils dilated. These include mild burning upon instillation of the drops, sensitivity to light, inability to focus at near, and blurry distance vision for some patients. These side effects should last no longer than 4 to 6 hours. Some patients find it difficult to drive after being dilated and thus bring a driver with them. Others find it difficult to do desk/close work immediately after being dilated.

Yes, I wish to be dilated.

No, I do not wish to be dilated.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received/reviewed a copy of Jane M. Therrien, O.D., Notice of Privacy Practices.

Date _____ Print Name _____

Signature

OFFICE PAYMENT POLICY

CO-PAYMENTS: Due each visit after seeing the doctor.

INSURANCE: We will bill your insurance as a courtesy. Your signature gives us permission to bill your insurance. Deductibles, patient balance responsibility beyond insurance, and all balances are due in full at the end of the monthly statement billing.

SELF-PAY: Payment is due in full at time of service. There is a \$25.00 charge on all returned checks.

PATIENT RESPONSIBILITY: Balances are due in full at the end of the monthly statement billing.

NON-COVERED SERVICES: Services not covered by insurance are the responsibility of the patient/guardian. Non-covered services vary between each insurance company.

I have read the above Office Payment Policy and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand there is no fee accrued on current accounts, however, I am also aware that delinquent accounts beyond 90 days are subject to other collection means at my own expense, including, but not limited to a \$20.00 per month charge to help defray the cost of a severely delinquent account.

I have read, understand and agree to the above Office Payment Policy in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given payment information to the best of my knowledge for complete and timely payment.

Signature

Date