



**FIRSTEYECARE**  
*Vision Made Clear*

**Retinal Evaluation**

As part of a comprehensive eye exam, Dr. Furr and Dr. Colston recommend ALL patients have the internal health of their eyes thoroughly evaluated every year. This is performed as either a **dilated** retinal exam or the **Optomap®** retinal imaging. Dilation may still be necessary in addition to retinal imaging for some medical purposes.

The retinal evaluation checks the overall health of the eye. Also, it can assist in early diagnosis and documentation of common problems:

<p><b>Macular Degeneration</b>  <b>Glaucoma</b>  <b>Retinal Holes or Detachments</b>  <b>Diabetic Retinopathy</b></p>	<p><b>Many systemic diseases including:</b>  <b>Diabetes</b>  <b>High blood pressure</b>  <b>High cholesterol</b></p>
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**The Optomap®:**

- Not covered by insurance, Costs an additional \$39
- Fast, easy, no side effects
- Permanent record for your file that allows your doctor to review your images with you annually

**Dilated Eye Exam:**

- Great for ages 5 and up
- Included in Exam price
- Required for all diabetic patients
- Common side effects include:
  - Light Sensitivity
  - Blurred vision for 4-6 hours

**I choose to have the Optomap® Retinal Imaging (circle one):**      **YES**      **NO\***

\*If NO, then a dilated eye exam is recommended.

**Are you Diabetic ?**

**Our doctors dilate all of our diabetic patients because vision lost to diabetic retinopathy is preventable. Early detection and treatment can reduce the risk of blindness by 95%. Because diabetic retinopathy often lacks early symptoms, people with diabetes need a comprehensive dilated eye exam at least once a year. Your primary care doctor will also be provided with documentation that you have had a dilated eye exam when provider information is given .**

**Patient/Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**FIRSTEYECARE**  
*Park Forest*

Amanda Furr, O.D.

Ben Colston, O.D.

**Release of Information**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**I authorize the release of my medical information including any claims information to the following person(s):**

- Spouse:** \_\_\_\_\_
- Child(ren):** \_\_\_\_\_
- Parent:** \_\_\_\_\_
- Other:** \_\_\_\_\_
- Information is not to be released to anyone.**

**This Release of Information will remain in effect until terminated by me in writing.**

\_\_\_\_\_  
**Printed Name of Patient or Legal Representative**

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

**National Security-** We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

#### **Appointment Reminders**

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

#### **Your Rights as a Patient**

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information if you determine it to be inaccurate or incomplete.
- You have the right to receive an account of disclosures of your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

To exercise any of these rights, send a written request to Park Forest Eye Care at the address or fax shown at the beginning of this notice.

#### **Our Notice of Privacy Practices**

Park Forest Eye Care is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office and post it on our website.

#### **Complaints**

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office or the U.S. Department of Health and Human Services, Office of Civil Rights. You will not be retaliated against in any manner for a complaint.

#### **For More Information**

If you want more information about our privacy practices, call or visit Park Forest Eye Care at the address or phone number shown at the beginning of this notice.

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Signature

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Date



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## **Contact Lens Evaluation**

The **Comprehensive Eye Exam** performed by Dr. Furr and Dr. Colston includes a full examination of the health of the eye and a prescription for glasses when necessary.

The **Contact Lens Evaluation** is a separate evaluation that is performed during the eye exam and provides the doctor with the parameters to fit you in contact lenses.

There is an additional charge for a Contact Lens Evaluation which includes follow up visits for **90 days** after your initial visit.

Over 90 days: additional refitting cost

Cost determined by the doctor based on complexity and number of visits required to perform fit and vision

I understand that the **Contact Lens Evaluation** is an additional charge which includes follow up visits and wish to be fit in contact lenses today:

**Patient/Parent Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_