CONSENT TO PHONE/EMAIL CONSULT

and FEES, when applicable

The high volume of patients who need appointments in contrast with the reduction in available appointments due to COVID-19 restrictions has resulted in many optometry practices' usage of phone consultations as a means for patients with certain eye issues to "be seen". **Freelton Eye Care** has now additionally adopted this strategy to better serve our community in such an unprecedented and challenging time.

I, _____, understand that IF I am NOT covered by OHIP, I will be responsible for paying the fee for phone consultation/advice and any therapeutic product obtained from our office, and allow **Freelton Eye Care** to use my credit card information to process this payment and send a receipt electronically, or by other contactless means.

OHIP# _____Version Code _____

Expiry_____

Check Preferred Method of Payment *(if purchasing product and/or not OHIP)*:

- **CREDIT CARD (Debit must use e-transfer)**

Card Type _____

Name of Card Holder _____

_____Expiry _____

Security Code _____

- **E-TRANSFER**

Must be set up with online banking; available through all financial institutions

Please send payment to freeltoneyecare@gmail.com

- **CALL OFFICE with card information**

I, _____, consent to providing health information over the phone to my doctor for the sole purpose of treatment, and agree to this form of analysis and diagnosis. I understand that my consult concludes when my treatment duration is complete.

Signature _____ **Date** _____