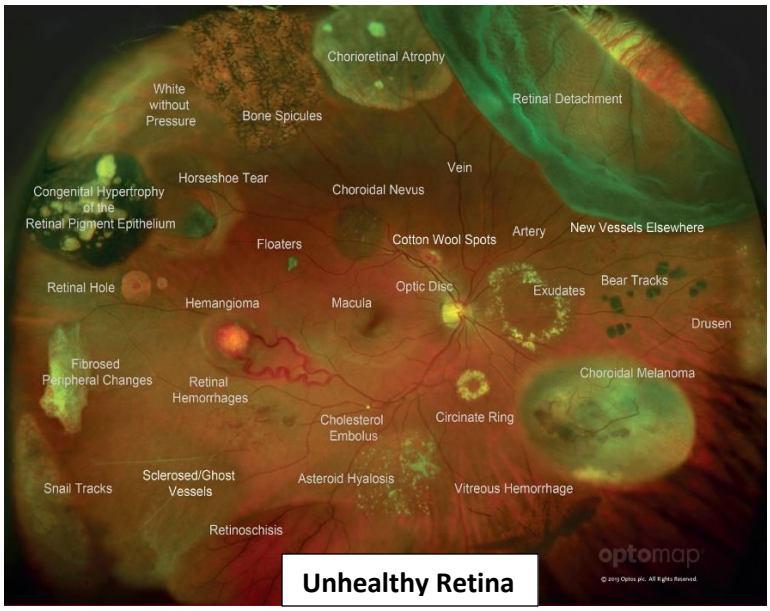
OPTOMAP RETINAL EXAM

In our continued efforts to bring the most advanced technology available to our patients, **Image EyeCare Optometry** is proud to announce the **OptoMap Retinal Exam** as an integral part of your eye exam today.

Many eye problems can develop without warning and progress with no symptoms. Early on, you might not even notice any changes in your vision. However, diseases such as Macular Degeneration, Glaucoma, Retinal Tears or Detachments, as well as other health problems such as Diabetes and High Blood Pressure can be detected with a thorough exam of the retina. The retina is the part of your eye that catches the image of what you are looking at, similar to the film in a camera.

OptoMap Retinal Exam provides:

- A digital scan to confirm a healthy eye or to detect the presence of the disease.
- An overview or map of the retina, giving your doctor a more detailed view than can be achieved by no other means.
- The opportunity for you to view and discuss the OptoMap images of your eye with your doctor at the time of your exam.
- A permanent record for your medical file, enabling your Doctor to make important comparisons if potential problems appear at future examinations.



Your Doctor strongly believes the OptoMap Retinal Exam is an essential part of your Comprehensive Eye Exam and highly recommends it for all patients every year.

The entire retinal exam procedure will only take a few minutes and may eliminate the need for dilation.

_____Yes. I do want the OptoMap Retinal Exam **(Your copay may vary depending on your insurance but not exceed $39)**

_____Yes. I want to do pupillary dilation which may take 20 minutes to work and last for 3-4 hours with blurry near vision and light sensitivity. **Informed Consent:** I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions, and attorney fees, which may arise as a result of my choice or failure to comply with the recommendation of Image EyeCare Optometry and their employees, officers, directors, and agents. I am aware that choosing pupillary dilation with medication carries a very small risk of complication including angle closure glaucoma, and will accept medically necessary treatment if complications arise.

_____ I have elected not to have the Retinal Exam/Dilation today against the recommendation of my Doctor.

Patient's Name:_____ Date: _____

Signature: _____(Parent or guardian if minor)

IMAGE EYECARE
OPTOMETRY

I) Privacy Practice Disclosure (HIPAA):

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes theses uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Image EyeCare Optometry.

Patient' Name: _____

Signature: _____ Date: _____

II) Insurance Signature On File:

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Image EyeCare Optometry on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorize my doctor to act as my agent, as above.

Patient Signature: _____ Date: _____

II) Patient's Financial Responsibility:

Patient agrees to be responsible for payment of all services rendered on his/her behalf or his/her dependents. Patient understands that services may or may not be covered or reimbursed by his/her vision &/or medical insurance, including not by Medicare/Medical.

Patient Signature: _____ Date: _____