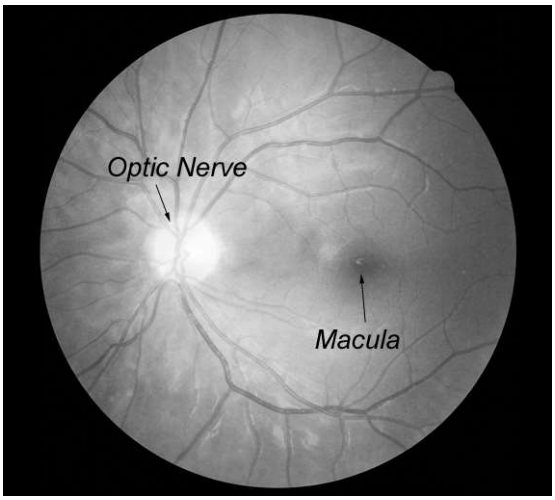
Digital Retinal Imaging Informed Consent

Our office recommends a diagnostic procedure called ***Digital Retinal Imaging*** which consists of capturing images of the inside (retina) of your eyes using a specialized digital camera. This procedure aids in the early detection as well as monitors eye problems such as ***Diabetic Retinopathy, Macular Degeneration, Glaucoma, Precancerous Lesions and other Retinal Diseases***. The images provide an excellent baseline from which your doctor can make future comparisons.



- Procedure is quick and painless.
- Retinal imaging is ***highly recommended*** if the patient has diabetes, hypertension, and/or family history of glaucoma or never had photos taken.

There is an additional non-refundable charge of $45 for this test.

_____ I consent to retinal imaging

_____ I do not consent to retinal imaging

AGREEMENT OF CONTACT LENS EVALUATION

I agree to pay Loudoun Eye Associates in full at the time of service for a contact lens evaluation if it is not covered under my insurance. A contact lens evaluation is defined as a measurement of corneal size and shape, as well as a diagnosed prescription to increase visual acuity. **In the state of Virginia, to purchase contact lenses, it is legally required to have a contact lens evaluation every year. The contact lens evaluation fees range from $90-$135 depending on what type of lens is needed. If you are a new wearer, there will be a $20 fee for contact lens care, insertion, and removal training.** The contact lens evaluation fees are separate from any other charges or services performed by the physician. The evaluation also includes two months of follow up care (as recommended by the doctor). The follow up care visits are for appointments related to contact lens fitting issues only, to be determined by the doctor. If the visit is due to another condition, there will be a separate charge. **If you choose to be refit for contact lenses or choose to be re-evaluated after two months from the original evaluation there will be a $45 fee. A re-evaluation after 6 months from the original evaluation will be charged a full evaluation fee.**

_____ I would like a contact lens evaluation today _____ I do not need a contact lens evaluation

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_____ _____ _____ / _____ / _____

Patient's Name (Please Print) **Signature of Patient or Legal Guardian** **Date**