Gold Coast Eye Associates

Welcome to 21st Century Eye Care

Dear Patient:

We have new highly sophisticated computerized instruments that now allow us to provide you with a more thorough medical analysis of your eye health.

Digital Retinal Imaging: Takes digital image of the retina (back part of your eye). The procedure assists the doctor in the early detection of many disorders including: cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and many other vision threatening conditions. These images are stored and compared with images from future testing that allows the doctor to observe even the smallest changes from past exams allowing for early detection.

Due to Covid-19, this procedure is mandatory for every routine eye exam.

1. You are a new patient to this office
2. You have never had these procedures performed in this office
3. You are age 50 or older
4. You or your family have a history of Macular Degeneration
5. You or your family have a history of Glaucoma or elevated eye pressure
6. You or your family have a history of Diabetes or elevated blood sugar
7. You or your family have a history of heart or circulatory problems
8. You are a smoker currently or in the past
9. You have a history of headaches or visual disturbance suggestive of neurological problems.
10. You have a retina disorder such as: detachment, tears, floaters, veils, or flashing lights
11. Your vision is not correctable to 20/20 in one or both eyes

Digital retinal imaging is termed "screening procedure"; and in most cases is **not covered** by medical or vision insurance companies. In the event that this procedure reveals a pathological or "at risk" condition then we will alert you that either the procedure is covered or may be covered, however; your decision to undergo this procedure should be made with the assumption that the procedure will be an out of pocket cost.

(signature required)

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Signature Print Name Date

ACKNOWLEDGEMENT OF RECIEPT

(signature required)

I acknowledge that I received a copy of **Gold Coast Eye Assoc. Ltd. Co.** Notice of Privacy Practices.

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Signature Print Name Date

INFORMED REFUSAL DILATION

I have been informed on this date by my optometrist of the need for a dilated examination of my eyes. It has been explained to me and I understand that a condition with the potential for partial or total loss of vision may exist and without dilation it may go undetected. Being advised of the above, I hereby declined to have my eyes dilated.

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Signature Print Name Date

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Signature of optometrist Print Name of optometrist Date

INFORMED REFUSAL TONOMETRY

I have been informed on this date by my optometrist of the need for an eye pressure test to screen for glaucoma. It has been explained to me and I understand that if I have glaucoma and a pressure test is not performed, the disease may go undetected with the potential for partial or total loss of vision. I have also been informed of the various means by which my eye pressure may be tested. Being advised of the above, I hereby decline to have an eye pressure test.

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Signature Print Name Date

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Signature of optometrist Print Name of optometrist Date

CONTACT LENS POLICY

(signature required regardless if doing a contact lens fitting or not)

I understand that I MUST come back for a follow up visit in order to finalize my contact lens prescription. This follow up must be scheduled within 1-2 weeks from the initial date of my exam (per the doctor's instructions). If I fail to come back for said follow up visits, I understand that the **maximum** grace period is **30 DAYS** from the date of my initial eye exam (keep in mind that most trial sets are only good for a **maximum** of 2 or 4 weeks). If I wait longer than that, I **WILL** be charged an office visit or additional fitting fee. *After 3 months, I will be required to have a new eye exam*.

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Signature Print Name Date