



PROCEDURE WAIVER / CONSENT FORM

These Tests are **NOT COVERED** by your insurance company. — These charges must be paid by the patient.

You have the right to participate in your health care decisions and to refuse any procedures recommended. We have an obligation to make sure you fully understand the reasons for the tests recommended and potential consequences of refusing to have those tests performed.

COMPUTERIZED RETINAL IMAGING takes a digital photograph of your retina. This state of art technology allows us to see a complete view of your retina without pupil dilation. This is the **most advanced diagnostic test available** to detect macular degeneration, glaucoma retinal holes and defects, and any optic nerve abnormality. We strongly recommend **ALL** patients have this test due to its advanced diagnostic applications. The fee for this test is \$38.00 and is not covered by most insurances.

- I elect to have the scanning digital image of my retina.
- I do not wish to have this test and prefer a dilated exam only.

CORNEAL TOPOGRAPHY SCREENING maps out the geographical shape of the cornea. The cornea is the transparent tissue in the front of the eye where contact lenses are placed. The cornea is also the first tissue which light encounters in the process of focusing on the retina in the back of the eye. With this test we can detect early stages of corneal disease such as keratoconus and abnormal changes which can occur due to extended wear contact lenses. We also use this test for more accurate contact lens fitting and to determine appropriate candidates for refractive surgery. We highly recommend this test to all contact lens wearers especially those who wear their lenses on an overnight basis. The fee for this test is \$35.00.

- I wish to have this test performed.
- I do not wish to have this test.

LASIK EYE SURGERY is the latest in refractive surgery techniques to correct nearsightedness, farsightedness and astigmatism. We feel this is an excellent option for those who wish to have good vision without the use of glasses or contacts. If you wish to discuss this further, please indicate on the line below.

- I would like to learn more about **LASIK**

Signed _____ Date _____

Phone: _____ My e-mail address is: _____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, INCLUDING INSURANCE CO-PAYMENT. THIS DOCUMENT IS TO SERVE AS MY SIGNATURE ON FILE.

PLEASE NOTE FOR YOUR CONVENIENCE, WE WILL BILL YOUR INSURANCE COMPANY. IF FOR ANY REASON INSURANCE DOES NOT PAY WHAT IS ESTIMATED, OR DELAYS PAYMENT MORE THAN SIXTY DAYS, THE BALANCE WILL BECOME THE PATIENT'S RESPONSIBILITY. WE WILL WORK WITH YOU TO GET THE DESERVED BENEFITS, BUT THE PATIENT AND/OR GUARDIAN IS RESPONSIBLE FOR PAYMENT TO THIS OFFICE. THE RELATIONSHIP IS BETWEEN YOU AND YOUR INSURANCE CARRIER, NOT BETWEEN OUR OFFICE AND YOUR INSURANCE COMPANY.

SIGNATURE OF PATIENT / GUARDIAN

Date