ACKNOWLEDGEMENT

1. I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim and any other claims thereafter.

2. By signing this form I acknowledge that I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

CONTACT LENS PATIENT: The contact lens fitting exam and the follow-up evaluation must be done within the six-month time period of the last complete eye exam, otherwise another complete eye exam is required. If the patient fails to return for the contact lens follow-up evaluation within three months of the initial fitting exam, then a new contact lens fitting exam is required.

Patient's Name: ____ (please print)

Patient/Legal Guardian's signature: ____ Date: _________________

Legal Guardian's Name: _______________________________________ (please print)

CONSENT – DILATING EYE DROPS

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow the optometrist to get a better view of the inside of your eye. The eye drops are necessary to diagnose certain eye condition.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome (average 4-6 hours). It is not possible for your optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Van B. Ly, O.D. and/or such assistants as designated by Van B. Ly, O.D. to administer dilating eye drops.

I decline dilating drops and elect to have Optomap fundus imaging. I understand that my insurance company will not cover this procedure as a routine screening. I understand there is a $35 fee for the Optomap imaging today.

Patient's Name: ____ (please print)

Patient/Legal Guardian's signature: ____ Date: _________________

Legal Guardian's Name: _______________________________________ (please print)