

DILATION CONSENT

Clinical studies have proven that a type of pupil dilation is required to accurately determine internal eye health and should be part of a comprehensive eye examination. In some cases, due to particular symptoms and eye history, or in some cases of young children, it is absolutely mandated. As with any test, prior approval from patient is required. Our office offers two different forms of dilation:

1: OptoMap

- No dilation drops needed and is highly recommended by Dr. Irons.
- Vision is NOT impaired.
- Takes 2 pictures of each eye, which is kept on file and can be compared to following year's pictures to help track ocular health or changes within the eye.
- Provides a wider view of the eye compared to the standard dilation method.
- OptoMap is an additional \$30 NOT covered by your insurance.

2: Dilation drops

- Care needs to be taken when driving back to home or office.
- Focusing at close distance will be impaired for approximately 3-5 hours.
- You will be sensitive to bright light for approximately 6 hours.

Please check the appropriate section indicating your choice:

- _____ Yes, I would like to have the OptoMap done today.
_____ Yes, I would like to have dilation drops today.
_____ No, I would like to refuse OptoMap / dilation drops today.

I understand by choosing NO to OptoMap / dilation drops that I relieve Dr. Irons of any liability from failure to diagnose such diseases of vision defects that would require OptoMap / dilation drops to expose.

FINANCIAL POLICY

1. If you do NOT have insurance or the required referral, payment is due in **FULL** at time of service.
2. With insurance, all deductibles and co-payments are due at time of service.
3. We accept assignment on many different insurance plans and we submit claims to those insurance carriers. All charges are your responsibility whether the insurance pays or not. Not all services are a covered service. We will assist you in obtaining a referral or authorization needed for services, but that does NOT guarantee payment to our office.
4. For your convenience, we accept Cash, Personal Check, Visa, MasterCard, Discover, and American Express. There will be a \$25.00 fee applied to all returned checks. These fees are subject to change without notice.

ASSIGNMENT AND RELEASE: I hereby authorize third party and insurance payments to be made directly to Dr. Irons and fully understand that I am the responsible party for all fees incurred by me at the above-mentioned facility. I also authorize the release of any information required for processing those claims.

REFUND POLICY: Here at Downtown Vision Source, we hope that you enjoy your eyewear! We have custom made this eyewear just for you and therefore we are unable to issue refunds for any reason. Thank you!

I, the undersigned, have read and understand the above policies.

Patient Signature: _____ Date: _____
(Parent or guardian if minor)

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read and/or received a copy of Dr. Alissa M. Irons Notice of Privacy Practices.

Patient Signature: _____ Date: _____