Patient Name: _____

Information and Consent for Dilated Eye Examination

Dilating eye drops are used to make the pupils of the eye larger to allow the provider to obtain a thorough view of the posterior segment of your eyes. Dilation frequently changes vision for a length of time which varies from individual to individual and may make bright lights seem bothersome. Potential side effects of the drops would include glare, blurred vision, reduced contrast sensitivity that may make you more prone to falls. It is impossible to predict what degree your vision will be affected. Please note that driving may be more difficult immediately after the examination. If you have concern about these circumstances, you may wish to make alternative transportation arrangements, although we still can provide you the assistance of temporary sunglasses after the examination.

I hereby authorize the provider and/or assistant to administer dilating eye drops. The eye drops are necessary for a complete exam of the lens, optic nerve, and retina. You further understand and acknowledge that you have been advised about potential risks that dilating drops may have on your ability to drive and will take appropriate steps to reduce this risk.

Do you want to have a dilated eye examination for your visit? Yes ☐ No ☐

X_____ ____/____/_____
Patient Signature or guardian **Date**

Information and Consent for Coordination of Benefits and Refraction (CPT 92015)

Thank you for choosing Valley Health Inc. as your eye care provider. We may need to perform a service called refraction which is a vision test to check your vision and determine your refractive status. A refraction is a diagnostic test that is used to determine the patient's best ability to see. A refraction is a specific measurement of the refractive state of the eye whereby a series of lenses are presented to determine which prescription provides the best corrected visual acuity. Based on the refraction results, there is the possibility that a prescription will not be necessary or need further adjustment from a previous exam. It is possible that there may be an adjustment period that caution should be exercised when driving or walking up and down until you are sure the prescription adjustment is settled.

PLEASE HELP US BILL YOUR CORRECT PLAN!

ROUTINE VISION COVERAGE (REFRACTIVE): Your vision insurance plan is intended to provide you with an annual baseline eye exam. Some medical plans also have "wellness vision benefits" as well. You will need to be aware of your vision insurance benefits and inform us of your coverage.

MEDICAL EXAMS: If you are symptomatic (itchy, watery, or red eyes, flashes, floaters, blurry, etc.) during your Routine Vision Exam and want the provider to address your symptoms or a medical problem is diagnosed, and you wish the provider to discuss and treat the condition, we can coordinate your benefits at your request and use both vision and medical plans. You may also choose to decline consultation/treatment and return at a different date to address the medical conditions.

If you choose to coordinate both plans the medical copay will apply or the vision plan copay (if no copay is required on your medical plan). Your visit will be billed to the medical and vision insurance(s) and subject to your medical deductibles and co-insurance. You may be billed for any balance remaining after your medical insurance is billed. You will not be required to pay for your refraction if you choose to coordinate your medical and vision benefits. You may still be responsible for some co-pays and co-insurance if both insurances are billed. Please understand that each patient's insurance coverage varies. The current office fee for refraction (CPT 92015) is $50. The fee is collected, if applicable, in addition to any co-payment, coinsurance, or deductible payments at the time of service.

I authorize coordination of benefits if a medical condition is existing or diagnosed at today's exam.
Yes☐ No☐ (If yes, medical co-pay, co-insurance, and deductibles may apply)
I accept full responsibility for the cost of this service (Refraction CPT 92015).

X_____ ____/____/_____
Patient Signature or guardian **Date**