DIGITAL RETINAL IMAGING INFORMED CONSENT

We now offer a state-of-the-art diagnostic procedure called Digital Retinal Imaging. This is an extension to the comprehensive eye examination which captures a **200 degree image** of the inside (retina) of your eye using a high-definition digital camera. Digital imaging can aid in the **EARLY** detection of eye diseases such as **DIABETIC RETINOPATHY, MACULAR DEGENERATION, GLAUCOMA, PRECANCEROUS LESIONS, METASTATIC CANCER TO THE EYE AND RETINAL HOLES OR BREAKS.** We highly recommend this procedure for all of our patients. While digital imaging is **not** a replacement for dilation, it is a **NON-INVASIVE** way to document a normal healthy retina at a given time. There is a nominal **fee of $45** for this test, which is **not covered by vision benefits.**

Please check (✓) one:

_____ **I DO** want to take this test at this time _____ **I DO NOT** want to take the test at this time

DILATED FUNDUS EXAMINATION INFORMED CONSENT

DILATION OF THE PUPIL is a procedure where eye drops are used to enlarge the pupils. This allows Dr. Spiewak to check for eye disease and conditions that may result in loss of vision. Your vision for driving and especially reading may become blurry, and your eyes will be sensitive to light for about 3-4 hours. Disposable sunglasses are available upon request. There is no additional fee for this test at the time of your visit. If you need to reschedule this portion of the exam at a different time, there is a **fee of $30**. The dilation is **NOT covered** by **GVS, CPS,** and **NVA vision plans.**

Please check (✓) one:

_____ **I DO NOT** want to have my eyes dilated at this time. I understand that the potential for partial or complete vision loss may exist and go undetected without dilation.

_____ **I WILL RESCHEDULE** an appointment for the dilation at a future date with a **fee of $30**.

_____ **I DO** want to have my eyes dilated at this time and understand my vision may be impaired.

RECEIPT OF PRIVACY, BILLING, AND SCHEDULING PRACTICES

Please initial each section to indicate acknowledgement.

_____ I hereby acknowledge that I have received, or had the opportunity to review a copy of the privacy practices of Dr. Magdalena Spiewak and Jamesburg Family Eyecare.

_____ I hereby authorize this office to release any information needed to bill for and expedite insurance claims, and I understand that I am responsible for all charges not covered by my vision or medical insurance.

_____ I understand all appointments made by me constitute reserved time set aside for me and that any changes require a minimum of 48 hours notice. Missed appointments are subject to a $50 missed appointment charge. In addition, 3 missed or canceled appointments without adequate notice may prevent me from scheduling future appointments.

I have read this document and its contents. My signature below indicates full understanding and acknowledgement of the options and policies described above.

_____	_____	_____
PATIENT NAME (PRINT)	PATIENT/PARENT SIGNATURE	DATE