



## **DILATION**

Eye drops are used that temporarily act to increase the size of the pupils. These drops also temporarily decrease the ability to change focus from one distance to another, mainly near focus. By enlarging the pupils, Drs. Floyd and Rosenberg can examine the inside of your eyes more thoroughly, and provide you the very best in eye care. Without pupillary dilation, certain eye diseases and abnormalities can go undetected. The disadvantages to having your eyes dilated include temporary slight stinging upon installation of the drops, blurry vision at near and light sensitivity. (Your driving may be affected, great caution is advised.) There is also a rare phenomenon called "Acute Narrow Angle Glaucoma" which is possible in a small group of patients. If you are at risk for this condition, the doctor will inform you of that risk in advance.

I give my consent for pupillary dilation today. Yes No \_\_\_\_\_ (Initial)

The following additional tests are **NOT** covered by Vision Service Plan or Davis Vision

## **RETINAL PHOTOS**

We can take pictures of the internal structure of your eyes to look for and document eye disease. In most cases this can be done in less than 10 minutes without dilating the eyes. This procedure also helps us detect subtle changes in your eyes over time which may sometimes go unnoticed. It will also help us determine the presence of retinal and optic nerve disease and monitor or detect glaucoma, diabetes, and many other problems.

**The additional cost for this procedure is \$24.00**

I would like to have these photos taken today. Yes No \_\_\_\_\_ (Initial)

**AUTOMATED VISUAL FIELD SCREENING** maps out your vision, checking areas of lost sight in the central and peripheral visual fields. The objective of this more thorough test is to detect early signs of sight-threatening eye conditions such as: Glaucoma, Optic Nerve disorders, and Tumors of the visual pathway. Virtually all of the major causes of blindness in the United States can be detected by changes in your visual field. Therefore, we highly recommend this test for all our patients as part of their comprehensive exam. The test takes approximately 3 minutes per eye.

**The professional fee for this additional service is \$24.00.**

I would like to have an automated visual field test today. Yes No \_\_\_\_\_ (Initial)

Date: \_\_\_\_\_



2410 S. Stemmons Freeway, Suite E ? Lewisville, Texas 75067 ? (972) 315-5202

### Acknowledgment of Receipt of Privacy Practices

Patient Name: \_\_\_\_\_

Patient Phone Number \_\_\_\_\_ Patient Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The **Notice of Privacy Practices** available in our office describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from SHARP EYES.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signing as a personal representative of the patient, describe the relationship and the source of authority to sign this form.

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name

### Patient Record of Disclosures

I wish to be contacted in the following manner (Check all that apply).

- Home Telephone \_\_\_\_\_  OK to leave a detailed message  Leave message with only call back number  
 Work Telephone \_\_\_\_\_  OK to leave a detailed message  Leave message with only call back number

Written Communication:  OK to mail to home address  OK to mail to work/office  OK to fax to \_\_\_\_\_

PLEASE NOTE: Uses and disclosures for TPO (Treatment/Payment/Healthcare Operations) may be permitted without prior consent in the case of an emergency.

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### FOR OFFICE USE ONLY

#### Record of Disclosures of Protected Health Information

Date	Disclosed to Whom	Address or Fax #	Disclosed by whom	Time