



Informed Consent for Pupillary Dilation

The pupillary dilation is the best method for evaluation of the RETINA and OPTIC NERVE, and is performed routinely. Evaluation of the retina/fundus *without* pupillary dilation may allow for sight and/or life threatening disease, hemorrhages, tumors, etc., to go *undetected*.

Pupillary dilation is pain-free, relatively easy, with minimal after effects. Most patients suffer no loss of distance vision from the dilation drops, however, some experience a mild decrease. Near vision (arm length and closer) will be blurred 2-4 hours afterwards. Bright lights and sunshine may be bothersome and a slight headache may occur. We will supply a disposable pair of sunglasses if you did not bring your sun wear with you today. Special precaution is recommended for driving, operation of heavy equipment and, in few cases even walking.

Less than 1 in 40,000 patients suffer serious side effects from dilating drops. The symptoms are usually eye pain, intense headache and possible nausea and may not start immediately. If after leaving the office, you experience eye pain, cloudy or steamy vision or severe headache, call us immediately.

PLEASE MARK ONE CHOICE BELOW:

_____ I have been informed of the benefits/risks, and **choose** to have pupillary dilation performed

_____ I have been informed of the benefits/risks, and choose to **reschedule** the pupillary dilation.

_____ I have been informed of the benefits/risks, and **refuse** to have pupillary dilation performed.

Signature: _____ Date: _____

Contact Lens Professional Services and Fees

Contacts Lenses are a Medical device that needs to be evaluated and prescribed on an annual basis per FDA guidelines. The Doctor and Staff will evaluate the Contact Lens and the health and integrity of the Cornea, Lids, Tear Film and its associated structures. This is done as a Fitting and Training for New Contact Lens patients and also for Current wearers. This assessment is in addition to the Visual Health Examination and warrants an additional professional fee. If patient is unable to wear contacts or cancels the Contact Lens Fitting and Evaluations, the patient will only be responsible for Half of the Evaluation Fee.

Fitting / Evaluation Fee	Description of Fitting / Evaluation
\$50	Patient wearing same brand / type of Contact Lens and has same or different power.
\$70	Patient trying new brand / type of Contacts, requiring follow-up appointments. Covers follow-ups for 1 month and necessary Contact Lens trials.
\$110	1-on-1 initial training on CL insertion and removal into Spherical Contact Lenses; Covers follow-ups for 1 month and necessary Contact Lens trials.
\$130	1-on-1 initial training on CL insertion and removal into Toric, Multifocal, Colored or RGP CL's. Covers follow-ups for 1 month and necessary Contact Lens trials.
\$300	Patient needing Medically Necessary Contact Lens Fitting and Follow-ups. Covers follow-ups for 1 month and all necessary Contact Lens trials. (Covered by Insurance)

Signature: _____ Date: _____