Internal Examination of the Eye

OPTOMAP DIGITAL TECHNOLOGY IS COMPLETELY SAFE

Retinal problems such as macular degeneration; glaucoma, retinal holes, retinal detachments and diabetic retinopathy can now be seen ***without*** dilation for most patients. All of our doctors recommend ALL patients have a digital image annually with the new State-of-the-art scanning digital imaging system. ***Early detection is crucial!***

___ I elect to have a digital image of my retina. Fee- $39.00 (***not*** covered by insurance)

___ I prefer a dilated exam. This will also add 30 minutes to your exam. No Extra Charge

Print Name _____

Patient Signature _____ Date _____

Dilated Exam	**VS**	**OptoMap Exam**
1. Blurred near vision for 4-6 hours. 2. Sensitivity to light for 4-8 hours. 3. Longer office visit approx. 30 min 4. Only doctor can see the retina. 5. No permanent record of the retina in your medical history.		1. No blurred vision. 2. No sensitivity to light. 3. More efficient office visit. 4. Patients can see their own retina. 5. Retinal image becomes permanent part of the patent's medical record

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed, but that you are not required to agree to these requested restrictions. I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected

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I have read and understand my rights under HIPAA Policy

Patient Signature _____