

Dilation Consent

Dilation is important part of a complete eye exam that can help the doctor detect systemic diseases like diabetes and physical changes to the eye such as cataracts. Dilation will make your pupil (the black part of your eye) large so that our doctor can get a better look at the back of the eye. The dilation will make reading things up close difficult, and make lights seem brighter than usual. This will last for 2-3 hours, although it can last longer in some people. Most people will be able to drive once their eyes are dilated, as long as they have sunglasses (which we provide).

If you feel uncomfortable driving while your eyes are dilated, it may be best to have a driver. Please note there is a **\$15.00** additional charge for having your eyes dilated if no insurance. If you have insurance, this procedure **may be** covered by your plan at **no charge**.

I would like my eyes dilated today.

I would like to re-schedule to come back for the dilation.

I do not want my eyes dilated (please read below).

If refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Retinal Photography

To provide you with the best patient care possible, we offer digital retinal screening photo. This is a new method of examining and documenting retinal findings, often without the use of dilating eye drops. This test is recommended for everyone since the health of the eye can change at any time, often without symptoms. Depending on each patient's specific medical needs the doctor may recommend both digital retinal photos and dilation. Both patient and doctor view images together, providing patient education and disease management as well as baseline images to compare against any future changes.

Please note there is a **\$35.00** additional charge for this procedure and is **not** covered by most insurance plans.

I would like to have the retinal photos performed.

I do not want to have the retinal photos performed.

Acknowledgement Of Receipt: I acknowledge that I have been offered a copy of **El Paso Eyeworks**, ""Notice of Privacy Practice"". (Version April 14, 2003).

Patient Signature: _____ Date: _____

Print Name: _____