Screening Digital Retinal Photography

In our continuing efforts to bring our patients the most advanced technology, our office is proud to announce the addition of the CANNON Digital Retinal Imaging Camera as an important part of your eye examination today. The doctor is concerned about retinal problems including ***Macular Degeneration and Glaucoma***, as well as systemic diseases such as ***Diabetes, Stroke and High Blood Pressure***. These conditions can lead to partial vision loss or blindness, and often can develop *without warning* and can progress *without symptoms.* The digital photograph provides:

- A detailed view of the retina
- The ability to view your digital image with your doctor during your examination
- An annual, permanent record for your medical file, which gives your doctor BASELINE pictures for comparisons and for tracking and diagnosing potential eye diseases in the future.

Digital Retinal Photography is ***painless and non-invasive.*** It is comparable to taking a baseline ***dental x-ray***. Retinal photography is especially important for those who have a personal or family history of ***Glaucoma, Diabetes, High Blood Pressure, Retinal problems or a high prescription.***

The fee is **$10 per eye** for screening photographs
(some insurance plans cover this procedure, ask your doctor for details).

_____YES, I would like to have retinal photography
_____NO, I have read and understand the above information and DECLINE to have retinal photography
(your doctor may recommend baseline photographs based on the results of your examination).

Pupil Dilation

Visual Field Screenings and the Doctor's standard evaluation examine your central retina, the most important area. When the pupil is small, the doctor is unable to examine the far peripheral areas, or outskirts of the retina. Therefore, many types of eye diseases, such as retinal detachments, holes, tears, and ocular tumors, can remain hidden, and many times occur without symptoms. Eye drops are used to widen the pupils to allow your doctor to view the entire retina. **Eye drops may also be necessary to assist in the determination of the eye glass prescription, especially in children. *(This procedure is included in the cost of your examination).***

Dilation is recommended for all patients, please answer the questions below:

Yes___ No___ This is your first examination or you have not been dilated in over 2 years or over 55 years old
Yes___ No___ You are highly nearsighted (-5.00 D and over)
Yes___ No___ You have **Diabetes, High Blood Pressure**, or health problems affecting the eyes
Yes___ No___ You have suffered recent head or eye injury, or suffer from **headaches**
Yes___ No___ You have experienced sudden onset of **"floaters" or "flashes of light"**

Dilation drops widen the pupils in approximately 15 minutes, and the examination takes about 5 minutes. The drops wear off in 2-4 hours. Side affects of the drops include light sensitivity (complementary sunglasses are provided if needed) and near vision blur (distance vision is relatively unaffected-**YOU CAN STILL DRIVE**-but having a driver is helpful). Some eyes may not be suitable for dilation, and your doctor may advise not to have this procedure.

If you have any questions regarding this procedure, please ask your doctor. Please initial below:

_____ I have read the above description, understand the procedure and **agree** to have pupil dilation.

(_____ I have read and understand the above information and *DECLINE* to have pupil dilation).
Despite your note to decline, your doctor may still recommend this procedure once in the examination room.

Dr. Jennifer Geertz and Associates
Independent Doctors of Optometry Dr. Jennifer Geertz, HIPPA Coordinator/Contact Person
9450 W. Joliet Road, Hodgkins, Illinois, 60525 (708) 387-2190, (708) 387-2292 Fax

HIPPA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Jennifer Geertz, O.D. and Associates Notice of Privacy Practices.
***I authorize release of all information related to the claim(s) to all authorized parties (for insurance claims and billing purposes only). I fully acknowledge that I am responsible for any amount not paid by my insurance carrier.**

DATE_____ Patient, Parent, or Guardian Signature: _____