

CONSENT / ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY

I consent to examination, diagnosis, and treatment by Eagle Rock Eyecare LLC.

I authorize release of medical information necessary to process insurance claims and assign benefits directly to the provider. I understand I am financially responsible for all charges not covered by insurance.

I acknowledge that co-pays and deductibles are due at check-out. Insurance is a contract between patient and insurer. I understand that my insurance plan may not cover all services, including refractions (\$55.00), retinal screenings, contact lens fittings, or materials. Unpaid balances may be sent to collections if not settled in full.

Patient Name: _____

Signature: _____ Date: ____ / ____ / ____

RETINAL IMAGING AND DILATION CONSENT / REFUSAL

Our standard of care entails digital imaging that captures a high-resolution, up-to-200° image of the retina without dilation (\$39.00). Alternatively, we offer a dilated exam to check for retinal tears, detachment, glaucoma, and diseases such as diabetes and hypertension. Side effects from dilation drops include blurry vision and light sensitivity for 4-6 hours. If I decline both, I assume all risks associated with the failure to detect, diagnose, or treat any eye conditions. Choose ONE:

Retinal imaging (no drops) Dilation (+side effects) Refuse imaging AND dilation

Patient Name: _____

Signature: _____ Date: ____ / ____ / ____

ACKNOWLEDGEMENT OF VISION PRESCRIPTION RELEASE

I acknowledge that I am provided with a copy of my eyeglass prescription and contact lens prescription (if applicable) after today's eye examination.

Patient Name: _____

Signature: _____ Date: ____ / ____ / ____