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 ($60.00), 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 OR REFUSAL

Our standard of care involves digital imaging that captures a quick, high-resolution, up-to-200° image of the retina without dilation ($39.00). This screens for retinal tears, detachment, glaucoma, and conditions like diabetes and hypertension. Alternatively, we can offer a dilated exam. Dilation requires an additional 20-30 minutes, and side effects from dilation eye 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 internal eye problems. Select ONE:

☐ Retinal imaging (no drops) ☐ Dilation (with drops) ☐ 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 the eye examination.

Patient Name: _____

Signature: _____ Date: _____