



CARY FAMILY

EYE CARE

I give permission for _____ to be seen for an eye exam at Cary Family Eye Care without myself or another parent or legal guardian present. I authorize Cary Family Eye Care to bill my insurance company, if applicable, for the exam and understand that I am responsible for any copayment or other amount not covered by insurance. _____ (initial)

I authorize Cary Family Eye Care to perform Optomap Wide-Field Retinal Imaging. This test provides a comprehensive view of up to 82% of the retina in one image. The test is quick, painless, and becomes a permanent part of your eye health record so we can monitor it over time. The Optomap can also decrease the frequency of dilation for many patients. I understand the fee for this test is \$39 and is not covered by insurance. _____ (initial)

I decline Optomap Wide-Field Retinal Imaging. By declining this test, you understand you may be limiting our ability to perform the most extensive analysis of the health of your eyes. _____ (initial)

I authorize Cary Family Eye Care to use topical eye drops for diagnostic purposes such as checking the eye pressure and/or dilating the eyes. _____ (initial)

(If applicable) I authorize Cary Family Eye Care to perform a contact lens evaluation, and understand that additional fees will apply which may or may not be covered by my insurance. I also understand that I will be responsible for any fees not paid by insurance. _____ (initial)

Print name: _____

Signature: _____

Date: _____