PRIMARY FOCUS EYE CENTER **Dr. Shawn M. Kurtz, OD**

As part of the comprehensive eye examination, it is recommended that **ALL** patients have the internal health of their eye thoroughly evaluated every year. This is performed as either a **dilated** retinal exam or the **Optomap** retinal imaging. Our practice is pleased to provide all of our patients with the most highly advanced technology available in retinal screening today! Our ability to view your internal retinal health is now dramatically improved with the **Optomap**. Dr. Kurtz is concerned about uncovering and documenting problems such as macular degeneration, glaucoma, retinal holed or detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Systemic diseases such as **diabetes** and **high blood pressure** can also be discovered during a retinal exam. **Just as your dentist regularly takes pictures of your teeth or mammograms are used for early detection, your eye deserve the same quality care.** These health conditions are difficult to detect without the **Optomap** retinal exam or **dilation** of the pupils with eye drops due to the limited view of the internal structures of the eye.

Optomap:

Provides and eye wellness scan.
Gives in depth view of the retinal layers (where diseases can start).
Allows your doctor to review you Optomap retinal image with you.
Provides an annual, permanent record for your medical file.
Is fast, easy, and comfortable.
Will NOT require dilating drops, which result in blurred vision and sensitivity to light for 4-6 hours. Some patients may need to have their eye dilated also.

PLEASE NOTE: THERE IS AN ADDITIONAL CHARGE OF $35.00 FOR THE OPTOMAP RETINAL EXAM WHICH IS NOT COVERED BY INSURANCE.

( ) I have read and understand the above, and **agree** to the **Optomap Retinal Exam.**
( ) I have read and understand the above, and **decline** the **Optomap Retinal Exam** but wish to have my eyes **dilated.**

HIPAA PRIVACY ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that this office is HIPAA compliant and acknowledge that the HIPAA policies are posted and available to read, upon request.

PATIENT/*Guardian* Signature: _____ **Date:** _____

PAYMENT POLICY:

I hereby assign all medical benefits, including all major medical benefits to which I am entitled including Medicare, Private insurance and any other health plans, to Primary Focus Eye Center. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Primary Focus Eye Center within 90 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. I understand that a late fee of $5. May be charged if I do not pay my balance within 30 days after receiving my statement. I certify that my responses on this form are accurate to the best of my knowledge. I **certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty.**

PATIENT/*Guardian* Signature: _____ **Date:** _____