Informed Consent for Dilation of the Eyes
In order to more fully examine your eye health, it is recommended that drops be used to dilate your pupils. *Without dilation, some ocular pathology may not be seen.* Your pupils will remain enlarged for 3-7 hours. You may notice a decrease in your focusing ability and experience some blurred vision (mainly up close) and light sensitivity. Some patients may have difficulty driving and may need to reschedule dilation in order to have someone drive them home. Every patient will be dilated, unless contraindicated or refused.

If dilation is refused, please initial and state why.
____ I understand the procedure and do NOT want to be dilated because _____.
Initials

Financial Responsibility & Authorization to Release Medical Information
I understand that exam fees are non-refundable. I request payment of the authorized insurance carrier to be made to Pastore-Tran Eyecare, Inc. for any services rendered. I authorize any holder of private medical information about me to release to Dr. Tran & Associates and their agents, any information needed to determine these benefits payable for related services. It is your responsibility to pay in advance for the deductible, co-insurance, or any other balance not paid by your insurance. *I understand that if my insurance is not accepted, payment will be made at the time of service.* If no payment is received from my insurance carrier, I will be responsible for full payment of services within 30 days of being notified by this office.

MEDICARE patients: I understand Medicare will only cover *medically necessary* exams. I acknowledge that it will only reimburse 80% of what is allowed and that I am responsible for the remaining 20% less any co-pays or deductibles required by my supplemental insurance. I understand that Medicare *does NOT cover contact lens fittings or refraction*, which determines the prescription for eyeglasses, and will pay the fee at time of service.

VISION INSURANCE patients: Benefits are NOT provided for services arising from medical (e.g., diabetes, macular degeneration, etc.) and/or surgical treatment of the eye(s) or supporting structures; orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses; any eye/vision exam required as a condition of employment; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency/program whether federal, state or subdivisions thereof; services provided by any other group benefit providing vision care; services rendered after the date an insured person ceases to be covered under the policy. Benefits may not be combined with any discount or other group benefit plans. Benefit allowances provide no remaining balance for future use within the same benefit frequency.

PROMPT PAY patients: Patients who *pay their bill in full at the time of service* will receive a prompt pay discount. This cannot be combined with insurance, and you *will not* be able to submit this bill to any insurance carrier for any reason. Discounts do not apply if payment is made after the time of service.

Patient Signature _____ Date _____

or Parent/Guardian Signature_____ Date _____
(if patient is under 18 years of age)

Print Name _____ Relationship _____