Dominic Pastore, O.D. & Associates **Pastore-Tran Eyecare, Inc.**

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.* New patients for their first visit will be dilated, unless contraindicated or refused. Established patients will be dilated every 1 to 2 years depending on the doctor's recommendation. Your pupils will remain enlarged for 3-7 hours. You will notice a decrease in your focusing ability and experience some blurred vision and light sensitivity. Some patients may have difficulty driving and may need to reschedule dilation in order to have someone drive them home. *If dilation is refused, please initial and state why.*

____ I understand the procedure and *do not* want to be dilated because _____.

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. Pastore & 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.

For 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 refraction*, which determines the prescription for eyeglasses, and will pay the fee at time of service.

For Prompt/Self 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/ Parent/Guardian Signature_____
Date_____ Print Name _____Relationship _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care or treatment. I understand that this information serves as: 1) A basis for planning my care and treatment. 2) A means of communication among the health professionals who contribute to my care. 3) A source of information for applying my diagnosis and surgical information to my bill. 4) A means by which a third party payer can verify that services billed were actually provided. 5) And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I have the right to restrict certain disclosures of protected health information to a health plan if I pay out of pocket in full for services rendered. I understand that I will be notified of any breach of unsecured protected health information. I understand I have the right to request an electronic copy of my electronic health record.
I acknowledge this office has a **Notice of Privacy Practices** that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

Patient signature or Legal representative_____ Date_____

For Office Use Only

I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for Pastore-Tran Eyecare, Inc. but was unable to for the following reason: □ Patient refused to sign □ Patient is unable to sign □ Other_____
Witness signature_____ Date_____