

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that the staff at **Coppell Vision Center** make every effort to inform you of your rights related to your personal health information.

_____ I have read (or given the opportunity to read) Coppell Vision Center's Notice of Privacy Practices and agree to continue my care with Coppell Vision Center under said terms.

List below the name of the person(s) to whom we may give information regarding your condition, treatment, diagnosis, or financial responsibility.

Spouse: _____

Parent: _____

Son/Daughter: _____

Other: _____

Initial here _____ if you wish that your information **not** be disclosed to anyone

List any specific person who should **not** have this information: _____

List the number(s) where we may reach you and **circle** the primary: _____

May we leave a detailed voicemail message on these numbers? Yes No

Knowing that standard email communication may not be totally secure, I still consent, if requested, to communications from my doctor or staff through my standard email. Yes No

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I hereby authorize Coppell Vision Center to release all information required to determine benefits and process any insurance claims to secure payment. I also authorize my insurance benefits be paid directly to the doctor, and I understand I am financially responsible for all unpaid charges not covered by my insurance. If needed, I authorize the use of this signature on all insurance claim submissions.

Patient

Date

If you are signing as a personal representative of the patient, please indicate your relationship

Representative

Relationship to Patient



At **Coppell Vision Center** we pride ourselves on providing our patients with the best possible standard of care. Because of this we perform the new Daytona **Optomap®** Retinal Exam with our patients. This non-invasive procedure allows your doctor to see a much broader and more detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **Dr. Pels and Dr. Elston strongly believe that the Optomap® Retinal Exam is an essential part of your comprehensive eye exam and prescribes it for all patients once per year.**

This scanning technology allows us to view the inside of your eye without the use of dilation drops. We may be able to detect early signs of glaucoma, diabetic retinopathy, retinal detachments, macular degeneration, hypertension, and many other serious vision and health concerns.



- Takes less than one second to take picture of up to 80% of your retina
- Digital record of the internal structure of your eye to compare at future visits
- No blurring or light sensitivity following exam
- You can see the inside of your own eye

A dilated exam can be performed at your exam, but please note that it may have an effect on your vision for 3-4 hours (blur and light sensitivity). Although the dilation is a very thorough way to look at the retina, there is no permanent record without photo documentation.

The doctor cannot fully assess the health of your eyes without the Optomap® or a dilated exam, either one or the other is recommended. Depending on the circumstances we may need to do both. There is an **additional charge of \$39** per patient for this service. Please note the **Optomap®** is NOT always covered by insurance plans, therefore you may be charged at the time of service.

_____ Please take the **Optomap®** photos of my eyes today (\$39 additional charge)

_____ I decline the photos today and request a dilated exam (no additional charges).

_____ I decline both photos and dilation of my eyes today. I understand and am aware that the doctors may not be able to thoroughly examine the back of the eye.

Patient's Signature (or Guardian)

Date