PATIENT NAME: _____

INFORMATION AND CONSENT FOR DILATED EYE EXAMINATION

Dear Valued Patient:

It may be important to your care today to dilate your eyes.
Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes.
Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you make wish to make alternative transportation arrangements, although a large number of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide after your dilation.
Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.
I hereby authorize the physician and/or such assistants as may be designed by him to administer dilating eye drops. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions. You further understand and acknowledge that you have been warned of the potential risks that dilating drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

I agree to have the dilation examination today.

_____/_____/_____
Patient Signature (or person authorized to sign for the patient) Date

I decline to have dilation exam today.

_____ ____/_____/_____
Patient Signature Date

INFORMATION AND CONSENT FOR REFRACTION

Thank you for choosing Mitchel Ashkanazy, M.D. for your eye care needs. We MAY need to perform a vision test called a “refraction” (description below) to check your vision today.

A refraction is a diagnostic test used to determine the patient’s best ability to see. A refraction is the specific measurements of the refractive state of the eye. A series of lenses are presented to determine which prescription provides the sharpest and clearest vision. This is an essential part of most ophthalmologic evaluations. This test is performed during your annual eye exam of if there has been a decrease in your visions since your last visit. This test is necessary to perform in order for your physician to determine the best visual acuity which is needed to evaluate for possible eye diseases. Occasionally the refraction is used as the basic information for prescribing glasses or other optical devices. However often time a refraction does not lead to prescription for glasses.

MOST INSURANCE COMPANIES INCLUDING MEDICARE DO NOT COVER THE REFRACTION TEST.

Our office fee for a refraction is $45.00 and it is collected in addition to any co-payments, coinsurance or deductible payments at the time of service. I accept full responsibility for the cost of this service.

_____ ____/_____/_____
Patient Signature (or person authorized to sign for the patient) Date

I decline to have the refraction examination today.
_____ ____/_____/_____
Patient Signature Date