

Diagnostic Testing Form



At the Eye Care Center, our doctors and staff are equipped with the latest, innovative technology to better serve all your vision and ocular health needs. Please review the material below. Thanks for your time.

Optomap Retinal Photography ONLY

With a quick snapshot inside the eye, the doctor can detect early changes that can be sight threatening. These photos are required by our doctor to provide better eye care to you here at the Eye Care Center. Photography is the leading diagnostic tool for both life & vision threatening diseases such as brain tumors, glaucoma, retinal detachments, and retinal bleeding due to diabetes & high blood pressure. In most cases, dilation is *NOT* required. There is a \$39 fee for this diagnostic testing.

- Photograph the inside of my eye for examination by the doctor.
- I am *refusing* a retinal photograph.
- Perform the above testing only if covered by my insurance.

Visual Fields Screening ONLY

The doctor requests that you have a peripheral vision test, while the doctor will focus on your central vision in the exam room. This will measure peripheral retinal function. There is an additional \$29 fee for this diagnostic testing.

- Screen my eyes for life & vision threatening disease with advanced visual field analysis.
- I am *refusing* visual field testing.

***Recommended* Package Exam Photography & Visual Fields (Packaging Saves You \$10)**

- Bundle Photography & Visual Field Screening. My doctor recommends this.
- Do not bundle my testing.

Dilated Pupil Examination

Dilation enlarges the pupil and allow the doctor to examine the inside of the eye for disease. In many cases, dilation allows the doctor to obtain a more accurate prescription. In children, dilation is especially critical. Dilation is a complimentary service.

- Perform a dilated pupil exam to thoroughly evaluate the health of my eyes.
- Reverse my eyes after dilation. This will 'un-dilate' my pupils smaller and my vision return to normal at a faster rate. There is a convenience fee of \$7 for this 'un-dilation'.
- I am *refusing* a dilated examination.

I acknowledge that I have also seen and understand the **Notice of Privacy Practices** for the Eye Care Center.

Patient's signature: _____ Date: _____
(Parent's signature if minor)

Eye Care Center