

Southlake Vision Associates

What is the reason for your visit today? _____

GDX EXAM & PUPIL DILATION INFORMED CONSENT

GDX Nerve Fiber Layer Analysis is the most advanced technology available today for analyzing the health of the optic nerve. Conventional testing methods often do not reveal glaucoma until after some vision loss has already occurred. The GDX exam is fast, easy, and comfortable, and allows the Doctor to detect glaucoma and other optic nerve diseases in their earliest stages, before vision is lost. This test is recommended once every three years for patients 18 to 40, and once a year for patients over 40 years of age.

The Optomap exam is fast and comfortable, and is utilized as an alternative to pupil dilation. It is a retinal scan that allows the doctor to assess the health of the retina, checking for retinal holes, tears, detachments, retinal tumors, diabetic eye disease and other systemic conditions that could previously only be detected through pupil dilation. Since this test does not require a dilated pupil, there are no side effects! Because full assessment of the health of the inside of the eye cannot be determined without the optomap or dilation, we strongly recommend that all patients choose this test yearly.

Please note: Insurance does not cover the Optomap Retinal exam. Your insurance may or may not cover dilation. The individual fees for these tests are \$20.00 each. If you choose to have both tests done on the day of your examination, the fee is \$35.00. Please ask our staff if there are any questions.

PLACE AN "X" IN FRONT OF THE APPROPRIATE STATEMENT BELOW:

- _____ Yes, I consent to having the GDX performed today.
_____ Yes, I consent to having the OPTOMAP performed today.
_____ Yes, I consent to having my eyes dilated today
_____ I would like to return at a later date for the dilation (\$20.00 fee)
_____ I decline these tests, understanding that the conditions mentioned above may go undetected without them

Signature of Patient or Guardian

_____/_____/_____
Date

RETURNING PATIENTS - MEDICAL HISTORY UPDATE:

Have you had any changes in the following areas of your medical history since the last time you were here?

Medications or Allergies: N / Y _____

Systemic diseases or surgeries: N / Y _____

Family Medical/ Eye history: N / Y _____

_____ All insurance coverage must be approved prior to your exam. **If we are unable to verify coverage, all charges must be paid in full at the time services are rendered.** If you are not eligible for benefits, or if your insurance denies coverage, your signature below indicates that you agree to be financially responsible for any unpaid balance.

- Your signature below indicates that you agree to forward within 14 days any monies paid to you by your insurance company that is owed to Southlake Vision Associates, and that you have reviewed the HIPPA Notice of Privacy.

Signature of Patient or Responsible Party

Printed Name

Date