CONSENT FOR DILATING EYE DROPS
INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. While dilated you may experience glare, difficulty focusing and contrast. It is not possible for your ophthalmologist to predict how much your vision will be affected. However, we advise not to operate any motorized vehicle or machinery as well as getting assistance with electric wheelchairs due to the risk of falling and/or injury. Because operating any motorized vehicle may be difficult after an examination, it's best if you make arrangements not to drive yourself.

Adverse reactions occur rarely, however dilating drops can provoke acute angle-closure glaucoma, allergic reactions, increased blood pressure, irregular heart rates, dizziness, and increased sweating. This is extremely rare and treatable with immediate medical attention. If your child is dilated and you notice any agitation or unusual response contact us or the emergency room immediately. Additionally we recommend sun glasses which we can provide to you.

I hereby authorize Dr. Palmer, Dr. Torrans and/or such assistants as may be designated by him/her to administer dilating eye drops. I understand the eye drops are necessary to diagnose my condition.

CONSENT FOR REFRACTION
INFORMATION REGARDING REFRACTION

Refraction is an essential part of a complete eye exam. It is the process of determining the eye’s refractive error, or the need for corrective glasses and/or lenses. Refraction is sometimes necessary depending on the patient’s diagnosis and/or visual complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, refraction is necessary to determine if this is due to a need for corrective lenses or due to a medical problem. A refraction will be done when it is necessary, to determine the cause for a decrease in your vision or simply to provide you with a means to achieve your best corrected vision.

Our mission is to ensure you have the very best possible vision. For this reason you have come to us for an eye exam. At the start of your eye exam, our technician will measure your visual acuity on the eye chart and review the quality and status of your glasses. If your vision is not 20/20, the technician will begin the process of refraction. After your exam, you will receive your new prescription which you can use should you break, lose, scratch, or wish to purchase new glasses afterward.

For patients anticipating cataract surgery, refraction is also required by insurance companies to provide documentation for the medical necessity for eye surgery. We must demonstrate that your vision cannot be simply improved with a glasses prescription. However most insurance plans, including Medicare, DO NOT cover the refraction. This is true even after you have had eye surgery.

Federal law requires that we bill for refractions. We can no longer offer this service for free and must charge you when it is performed. Our charge for refraction is $50.00. If this fee is made to Palmer Eye Center at check-out on the day of office visit, we will accept $35.00 for your refraction to defray billing costs. Although refractions are typically a non-covered benefit, all refractions are billed to your private insurance company and a refund issued to your account, should you insurer cover the charge.
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<th>Mr.</th>
<th>Mrs.</th>
<th>Ms.</th>
<th>Dr.</th>
<th>□ Single</th>
<th>□ Married</th>
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<tr>
<th>HOME PHONE:</th>
<th>CELL:</th>
<th>WORK PHONE:</th>
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*please provide 2 contact numbers if possible.

**EMERGENCY CONTACT:**

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<th>Employer’s Name:</th>
<th>Occupation:</th>
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<th>Employer’s Address:</th>
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<th>Spouse’s Name:</th>
<th>Spouses Employer:</th>
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**Responsible Party Information:**

If the patient is a child, Name of Guarantor:

Street Address (if different from above):

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<th>City:</th>
<th>State:</th>
<th>Zip:</th>
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**How were you referred to our office:** please circle and add name if applicable.

Previously seen in our office

Doctor's Name:

Friend/Family's Name:

**REASON FOR VISIT:** please circle

Cataract Evaluation

Lasik Evaluation

Diabetic Eye Exam

Glaucoma Exam

Referral by Physician

Dry Eye Exam

Routine - No Particular Problems

Possible Medical or Surgical Problem

Other, please explain:

**PAST EYE HISTORY:** please circle

Eye Injury

Infections

Double Vision

Muscle Imbalance

Glaucoma

Diabetic Eye Disease

Cataracts

Retinal Problem

Halos

Blurry Vision

Other, please explain:

**FAMILY HISTORY:** please circle

Blindness

Glaucoma

Arthritis

Cancer

Diabetes

Thyroid disease

Heart disease

High blood pressure

Kidney disease

Lupus

Stroke

Other, please explain:

**CIRCLE IF YOU HAVE THE FOLLOWING PROBLEMS:**

Blurr/Fuzzy Vision

Tearing or Discharge

Burning

Itching

Redness

Floaters/Cobwebs

Flashing lights

Dry Eye

Problems with Glasses

Other, please explain:
What medicines are you currently taking (include dosage and frequency): Skip if you will attach a list.

Pharmacy Preference: ____________________________ Location: ____________________________ Phone #: ____________________________

What are your allergies? Please specify: Skip if you will attach a list.

In the past 5 years, list any surgeries or injuries with date of occurrence: Skip if you will attach a list.

YOUR MEDICAL HISTORY: please circle

- HIV or AIDS
- Tuberculosis
- Drug Dependence
- Alcohol Dependence
- High Blood Pressure
- Diabetes
- Thyroid trouble
- Cancer
- Sinus Infection
- Headaches
- Skin Disorder
- Hay Fever
- Lupus
- Arthritis
- Blood transfusion
- Smoker
- Other, please specify:

ARE YOU NOW: please circle

- Pregnant
- Possible Pregnant
- Not Pregnant
- Unknown
- Using Contraceptives

Do you wear Contacts: Yes No What Brand/Power/B.C./Diameter? Which Cleaning Solution?

Do you wear glasses: Yes No If yes, how long have you had the current prescription?

Patient Acknowledgment of Having Received & Read or Been Read the Notice of Health Information Practices (HIPAA)

- I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices Palmer Eye Center.
- I understand that Palmer Eye Center is committed to treating and using protected health information about me responsibly.
- I understand my rights as it relates to my records at Palmer Eye Center and understand how information about me may be used and disclosed.
- I understand that my health record is the physical and legal property of Palmer Eye Center but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.
- I understand that Palmer Eye Center is required to maintain the privacy of my health information. Palmer Eye Center will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by Palmer Eye Center staff and physicians; billing to myself or a third-party payer; in addition, business associates of Palmer Eye Center may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person’s involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/ or law enforcement purposes.
- Palmer Eye Center may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.
- Palmer Eye Center may contact me via email.
- I have read and understand the Health Information Practices of Palmer Eye Center.

Patient Name: ____________________________ Signature: ____________________________

Date: ____________________________ Witness: ____________________________

List the names we can fully discuss your medical condition with:

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________