Dr. Howard A. Sherman, Optometrist

Name: _____ Date of Birth: _____ Chart #: _____

Dilation Consent

Dilation of the eyes is a diagnostic procedure that allows a more complete assessment of the health of the inside of the eyes. Dilation is necessary to thoroughly inspect the eye for the presence of tumors, glaucoma, retinal detachments, cataracts or other serious abnormalities. This procedure has been recommended by Dr. Sherman so that he can provide you with the most thorough eye health possible. Having your pupils dilated is a relatively painless procedure. **If** you agree to be dilated today, you need to be aware of the following: Care needs to be taken in driving back to work or home, though most patients find little difficulty in driving in familiar areas. If traveling a long distance, you may choose to reschedule the dilation, or make other arrangements for someone to drive you. Focusing at close distances will likely be impaired until the dilation wears off (approx. 3 to 5 hours.) **You will also be sensitive to light and will need sunglasses.** If you do not bring a pair with you, we will provide a pair of disposable sunshades for your comfort.

If the dilation is done during your exam (same day), there is **no** additional charge. However, **if you elect to reschedule the dilation for a different day or time; an additional fee of $40.00 will be charged, which is NOT billable to your insurance.**

I have read and understand the above. (Please INITIAL **one** option and sign below.

_____ 1. **Yes- TODAY**, I do want to have this procedure performed and understand the importance of a dilation exam.

_____ 2. **Reschedule (for another day),** I would like to reschedule the dilation. I understand it is **my** obligation to call the office and schedule the appointment, and the fee is **$40.00**.

_____ 3. **No**, I have elected **NOT to have this test done** and I release Dr. Howard A. Sherman from any liability resulting from my NOT having this test performed.

Signature: (X) _____ **Date**→ _____

If you are NOT the patient:

PRINT your name: →_____ **Relationship to patient:** →_____

Retinal Photograph Consent

We **highly** recommend that all patients over the age **of** 10 have a photograph taken of the inside of their eyes. These pictures are kept in your file so that views of the retina can be compared and the health of your eyes can be evaluated more objectively. These photos are used as a baseline from which to monitor your ocular health. The photographs document the blood vessels, nerves, and retina of the eye, thus enabling us to detect and treat many eye problems at the earliest possible moment. Our charge for this procedure is $75. If the photographs are done on the same day as your dilation, we will give you a $20 discount (Only for the uninsured). **Some insurance** companies cover the cost. ***NOTE****: Patients with a family history of diabetes, high blood pressure, glaucoma or vascular disease & Crohn's should* absolutely *have these pictures taken to document the health status of your eyes.* Please INITIAL one option & sign below.

___ **Yes** – I want retinal photographs of both eyes, ***IF TIME ALLOWS***. Otherwise, I understand that it is my responsibility to make a separate appointment.

___ **No -** I do not wish retinal photograph at this time.

Signature (X) _____ **Date**→ _____

If you are NOT the patient:

PRINT your name: → _____ **Relationship to patient**: → _____