**Chart No._____**

## INFORMED CONSENT FOR 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. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, 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 Dr. _____ and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

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

_____/_____
Witness / Date

**Refraction Policy**

Refraction is the process of determining the eye's refractive error and testing for best corrected vision, or need for corrective lenses (glasses or contacts). It is an essential part of an eye examination, but is not considered vision care and is NOT a covered service by Medicare or most insurance companies. It is in addition to your co-pay which is for the medical part of your exam. Our office fee for refraction is $30.00 and this fee is collected at the time of service (on the day of the exam).

**Acknowledgment**

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from, and not included in, the refraction fee.

_____ _____
Patient Signature (Parent for minor) Date