Optos Retinal Screening

- Alternative to pupil dilation
- Provides an ultra-widefield view of the retina
- $38 copay

❏ I ***AGREE*** to the screening Dr. Nielson recommends

❏ I ***DECLINE*** to the screening against the advice of Dr. Nielson

❏ I would like to ***TALK*** to the doctor about the screening

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Contact Lens Services

Contact lenses are medical devices that require additional time and training in addition to your routine eye exam. Pricing will vary depending on the type of lens and is due at the time of service.

The cost of contact lens services start at ***$60.*** This service will include any diagnostic lenses, any follow ups for 90 days, and a new contact lens prescription for the year. Any follow ups after 90 days from initial fitting will be subject to a $25 charge.

❏ ***Yes*** I would like this service

❏ ***No*** I do not wish to have this service

Notice of Privacy Policy: My signature acknowledges that a copy of The Eye Site's Privacy Policy has been made available to me. I hereby authorize any necessary medical treatment by the optometrist at The Eye Site, and agree to be financially responsible for my bill and any necessary collections for any services and/or materials rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize my insurance to make payments on my behalf to The Eye Site. Payments for services rendered are non-refundable. Your medical records will be electronically archived and all discarded documents are shredded to protect personal information.

Financial Responsibility: I agree to be responsible for payment of all The Eye Sites' charges. I also agree to be responsible for all professional fees covered by insurance or not. I understand the Eye Site is an independent practice and will bill me, my family, and /or other responsible parties for services provided. I understand for any balances unpaid over 30 days will be subject to a **$10.00 per month late charge.** The Eye Site uses an outside collections agency for any balance unpaid after 90 days.

Patient's Name:_____ **Signature:**_____

(parent/guardian if patient is a minor)

Today's Date:_____