



PERMISSION TO DILATE

If your eyes are dilated today to check the health of the back of your eye, you may be light sensitive and have blurred vision. We caution you against driving.

I give permission for my eyes to be dilated if needed.

NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have reviewed this office's Notice of Privacy Practices.
(printed name)

A copy of this notice will be provided to me upon request.

You have my permission to discuss my medical care or billing information with:

Name

Relationship

Phone

May we leave detailed messages on your home phone? yes no

May we leave detailed messages at work? yes no

For office use: Acknowledgement could not be obtained because _____

I am here today for: (please initial and date)

_____ Routine Vision Exam (will not be billed to insurance)

_____ Medical Eye Exam (will be billed to medical insurance)

I was referred here by: _____

Signature _____ Date _____

Name _____ DOB _____