CONSENT FOR MEDICAL EYE AND VISION EVALUATION AND TREATMENT

To include: Complete evaluation of visual abilities (refraction) and all eye health testing. This will include contact lens evaluation and management fees (if applicable) and an annual retinal imaging scan (for all patients) and a deep macular tissue scan (for all diabetic patients of any age and all patients 40 and over).

Fees:

- Comprehensive Eye Evaluation: $122
- Visual Evaluation/Refraction: $34
- Contact Lens Evaluation and Management Fee: Usually $140 or $152, but can be less or more in specific situations.
- Either Retinal Scan (under age 40 and not diabetic): $18
- OR - Retinal and Macular Scan (40 and older and diabetics of any age): $32

Patient Name: _____ Date of Birth: _____

I hereby authorize Fig Garden Optometry Optometrists and/or such assistants as may be requested by said physician to perform the above noted medical evaluation and treatments as explained to me. I hereby acknowledge and agree that if my insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I accept the recommendation for evaluation and treatment of my physician. I acknowledge that no warranty or guarantee has been made as to the results of any treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician. I further understand that my physician will inform me of the nature and character of any proposed treatment, of the anticipated results of this treatment, of the possible alternative treatment choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

The consent to move forward in relationship with Fig Garden Optometry and its physicians and technicians as stated to me or my representative is thus given as noted by signature.

_____ _____

Patient or Responsbile Party Signature Date