CONSENT FOR MEDICAL EYE AND VISION EVALUATION AND TREATMENT

To Include: complete evaluation of visual abilities (including refraction) and all pertinent and applicable eye health testing. This will include contact lens evaluation and management fees (if applicable) and an annual retinal imaging scan (for all patients every calendar year) as well as a dep macular tissue scan (for all diabetic patients – any age – and all patients age 40 and older).

Fees:

- Comprehensive Eye Health Evaluation: $155
- Refraction/Visual Evaluation (when done at same time as Eye Health Evaluation): $45
- Contact Lens Evaluation and Management Services: average- can be less or more: $177
- Retinal Scan for non-diabetes 39 and younger: $24
- Retinal Scan and Macular Scan for diabetes and age 40+: $38

Patient Name: _____ DOB: _____ / _____ / _____

I hereby authorize Fig Garden Optometry optometrist, and/or such assistants as may be requested by said physicians 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 a 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 on my representative is this given as noted by signature.

x

_____ _____

Patient or Responsible Party Signature DATE