Acknowledgement of Privacy Practices

HIPAA (Federal Health Insurance Portability & Accountability Act)

By signing below I understand that I have the right to request a copy of Starkville Eye Clinic's Privacy Practices.

_____
Print Patient name

_____ _____
Signature Date

Office use only

If patient refused to sign, document all good faith attempts to acquire a signature and explain why it was not obtained.

_____

_____

_____

Please list anyone whom you consent to have access to your health or billing information. You have the right to withdraw consent in writing at any time.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____
Signature Date

Starkville EYE CLINIC

Dilation Consent

Pupillary dilation is a safe and routine part of a comprehensive eye examination. However, this procedure does require the instillation of prescription eye drops. Therefore, your consent is required. Pupillary dilation is strongly recommended to ensure ocular health as it allows the doctor to gather a complete set of information about your eyes.

DUE TO INSUFFICIENT RESEARCH, DILATION WILL NOT BE PERFORMED ON PATIENTS THAT ARE PREGNANT.

____Yes, I wish to have my pupils dilated.

____No, I do not wish to be dilated at this time. I understand that this may keep the doctor from making a full assessment of my ocular health.

_____ _____

Signature (patient signature, guardian, or person representative) Date

IWellness OCT

This is a quick, non-invasive scan that aids in early detection of diseases within the retina, such as macular degeneration, damage associated with systemic diseases, damage associated with some medications, and other retinal diseases. Most retinal diseases have no symptoms in the early stages. This scan can detect vision threatening and systemic diseases in the early stages, before they can be detected by other means of evaluation, when they are the most treatable.

This is **NOT** covered by any insurance. If you wish to have this test, there will be an additional charge of $30.00. This test will only be performed on persons 18 and older.

_____Yes, I wish to do the Iwellness

_____No, I do not want the Iwellness