EL DORADO HILLS
OPTOMETRIC
CENTER

Patient Name_____

UNENCRYPTED TEXT MESSAGES AND EMAIL LANGUAGE

We offer helpful administrative information by regular text messaging and email like appointment reminders and general office information. There is some level of risk that information in a regular text message or email could be read by someone besides you. Please let us know if you would like us to communicate with you by email and text messages.

☐ YES – Please communicate with me by **email**. My email address is:

I will let you know right away if my email address has changed.

☐ NO – Please do not communicate with me by regular (unencrypted) email

☐ YES – Please communicate with me by **text message**. My cell phone number is:

I will let you know right away if my cell phone number has changed.

☐ NO – Please do not communicate with me by regular (unencrypted) text message

Optos Optomap Screening $39

The Optomap is a ultra-widefield (UWF™) retinal image. UWF retinal imaging is an important tool for the screening and diagnosis of ocular issues, such as retinal detachment, retinal holes/retinal tears, nevus (eye freckles), it can also indicate evidence of non-eye diseases, such as diabetes, hypertension and certain cancers.

☐ **I want to take advantage of the new, advanced technology**
☐ **I decline the Optomap screening exam** **Initials: ____**
☐ **Discuss with Doctor**

iWellnessExam $45 (not covered by insurance)

The iWellnessExam is a quick, non-invasive scan that allows our doctors to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages when they are most treatable. Specifically, diseases including age-related macular degeneration and glaucoma.

☐ **I want to take advantage of the new, advanced technology**
☐ **I decline the iWellness screening exam** **Initials: ____**
☐ **Discuss with Doctor**

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/ or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to El Dorado Hills Optometric Center for any services and materials furnished. If I have health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I acknowledge that I am financially responsible for all payments that are not paid by the insurance company or group, including any co-payments, deductibles, or non-covered services and verification or authorization of benefits is not a guarantee of payment by my insurance company.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name