ATLANTIC EYE

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INFORMATION REGARDING DILATING EYE DROPS

Listed below is helpful information on the testing being performed during your visit.
If you have any questions, please let us know.

Dilating eye drops enlarge the pupil of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of time your vision will be blurred and the degree of eyesight impairment varies from person to person.

Driving even in low light conditions may be difficult or impossible after an examination with dilating drops, and, if possible you should not drive yourself afterwards. Instead, we strongly suggest you make alternate arrangements for transportation after your examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

By signing below you authorize your Atlantic Eye provider and or their nurses or other assistants to administer dilating drops during the course of your treatment. You understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk.

INFORMATION REGARDING REFRACTION SERVICE AND FEE

Refraction is the process of the determining your best correct vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses.

Refraction is NOT a covered service by Medicare or most insurance plans. These plans consider a refraction to be a “vision” service and not a “medical” service. If your plan includes vision coverage, this service is typically covered. We will file the charge for the refraction with your health insurance as a courtesy.

Our office fee for refraction is $45.00 and this fee is due at the time of service in addition to any co-payment your plan requires. Should your insurance pay us for the refraction, we will reimburse you accordingly.

By signing below you acknowledge, that you have read and understand the refraction service and fee and accept full financial responsibility for the cost of a refraction.

CONTACT LENSES

Contact Lens evaluation, update of prescription, new fit and refit are NOT included in a routine eye exam. There is an additional charge for this service. Payment is due at the time of service.

I have read and understand All of the above information:

Patient Name _____ Date _____

Representative _____ Relation to Patient _____