HAMILTON MILL EYE CARE

PATIENT PORTAL ACCESS CONSENT

Please check the box below and sign the agreement should you wish to participate:

- ❑ Yes, sign me up!
- ❑ No, I do not wish to participate.

_____ _____
Print Name Email Address

_____ _____
Patient Signature Date

❖

RETINAL IMAGING CONSENT

____**YES,** I would like to have retinal imaging performed today.

____**NO,** I have read and understand the information regarding retinal imaging and DECLINE to have retinal imaging.

If you selected **NO** to having the retinal imaging performed, our doctors recommend a dilated eye examination to assess the health of your retina. The dilation is part of your examination and covered by your insurance. The dilation will cause blurred near vision and light sensitivity for approximately 4-6 hours after instillation.

____**YES,** I would like to have my eyes dilated today.

____**NO,** I would not like my eyes dilated today. I understand by declining dilation and retinal imaging, it limits the doctor's ability to thoroughly assess the health of my eyes.

_____ _____
Signature Date

❖

CONTACT LENS ASSESSMENT/EVALUATION CONSENT

The undersigned hereby acknowledges understanding the risks, benefits, and stated policies.

_____ _____
Patient or Parent/Legal Guardian Signature Date

_____
Print Patient Name

❖

PATIENT FINANCIAL POLICY STATEMENT

I have read the Patient Financial Policy and agree to abide it terms

_____ _____
Patient Name Date of Birth

_____ _____
Patient or Parent/Legal Guardian Signature Date