FAMILY EYE CARE

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contactus@safamilyeyecare.com

Patient Signature Page

Patient Name (Print)

Take your time to read the following, ask questions, you may request a copy, and initial/check applicable sections with final signature acknowledging receipt, reading, and acceptance.

1. _____ Notice of Privacy Practices & HIPAA Privacy Statement

2. _____ Financial Policy

3. _____ Contact Lens Evaluation Agreement

Please Check			
YES		**NO or N/A**	

4. _____ FDT-Frequency Doubling Technology

Please Check			
YES		**NO or N/A**	

5. _____ Dilation and/or Retinal Photography

Service	**Please Check**		
Type	**Today***	**Later****	**Decline*****
Dilation			
Retinal Photography			
Dilation & Retinal Photography			

*I authorize the staff to administer dilating eye drops and/or retinal photography.
**Patient must call to schedule within 30 days of last exam to avoid additional $30+ fee.
***I am aware of my options and risks and decline either procedure against medical advice.

Patient, Parent or Guardian Signature and Date