Hatfield Family Eye Care, PLLC.

REFRACTION CONSENT

Please be advised that most **MEDICAL INSURANCES** will not cover the refraction. The refraction is the portion of the exam that the doctor must perform in order to get your glasses prescription. If no vision insurance is available, the patient will pay out of pocket for the refraction.
(Soonercare will cover this refraction fee for patients who are between the ages of 0-20 years)

_____ YES: I understand that I will receive the refraction, and I may be responsible for the $17.00 fee.
_____ NO: I **do not** want to receive the refraction. I understand I will not receive a vision prescription.

CONTACT LENS FITTING

If you desire a contact lens prescription at this visit there will be a fitting/refitting fee. If you've never received a contact lens fitting from our office, the charge will be between $65 and $85 depending on the type of lens you wear. If you've already received a fit at our office any year prior to this visit, there will be a refit fee of $45. Insurance may pay a portion of these fees.

_____ YES: I am interested in a contact lens fit.
_____ NO: I am **not** interested in a contact lens fit.

RETINAL IMAGING CONSENT

Hatfield Family Eye Care is proud to announce that we now have the technology available to capture retinal images. This advancement allows us to provide an even higher standard of care to all of our patients. The retinal images may be used to detect problems that could be detrimental to a patient's vision. It is recommended that all patients receive retinal imaging. If you choose not to participate in the retinal imaging portion of the examination, you are declining the doctor's recommendation to obtain a comprehensive view of the retina. Retinal imaging may or may not be covered by your insurance. Payment depends upon diagnosis. If insurance does NOT cover, there will be a patient responsibility of $20.00 due at the time of service. This service will be provided to all patients; UNLESS you indicate below that you would like to decline this service.

_____ YES: I am interested in retinal imaging. I understand there may be a charge for this service.
_____ NO: I choose to **decline** retinal imaging. I understand that I will receive a lower standard of care.

PRIVACY STATEMENT

I acknowledge that I have received a copy of the Hatfield Family Eye Care / Lisa Hatfield, O.D., Notice of Privacy Practices. I understand that my private information will not be shared with third parties, unless I have consented to share my records.
Please sign below to verify that you have read and understand each of the consents provided.

Signature:_____ **Date:** _____