OPTOMAP and Insurance Coverage at Colorado Eye Care:

The Optomap provides a **baseline**, broad and detailed view of the retina. In **some** cases, it may eliminate the need to be dilated.

______ I elect to have the Optomap Digital Retinal Imaging of my retina for **$50** and understand that this may not be covered by my insurance.

______ I decline the Optomap Retinal Image and chose to be dilated, if indicated.

***Dilating drops can blur your near vision for a length of time which varies from person to person.**

Print Name:___________________________Signature:________________________Date:___________

Insurance coverage at Colorado Eye Care:

I hereby assign to Colorado Eye Care (CEC) or any other third party, benefits available for health services provided to me. I understand that CEC has the right to refuse or accept assignment of benefits. I understand that I am responsible to pay **ALL** non-covered services, including those for refractions, copayments, deductibles, and co-insurance at the time of service**. I understand that I am responsible for providing accurate insurance information at every visit—failure to do so may result in nonpayment by the insurance carrier and I will be responsible to pay all fees incurred.**

Print Name_______________________ Sign Name______________________Date____________________

☐ **Medical Eye Examination—**You must have a MEDICAL INSURANCE benefit that covers your eye care. These examinations are for the diagnosis and treatment of eye conditions and diseases**. My insurance may not cover the cost of a refraction (the test which we do to determine any changes in your glasses prescription) which is $52. I will pay this at check out today is applicable.**

☐ I do not want a refraction today.

☐ I do not have medical insurance and I agree to pay all costs associated with today's visit