Name: ______________________
Date: ______________________

CROSSROADS VISION CARE

J. SCOTT BLASE, O.D.
9250 FM 78
Converse, TX 78109

INSURANCE ASSIGNMENT & FINANCIAL RESPONSIBILITY

I hereby authorize my insurance benefits be paid directly to J. Scott Blase / Crossroads Vision Care and I am financially responsible for co-pays, deductibles, non-covered services, all denied insurance claims and any unpaid balance due on my account. I authorize this office to release any information required to process any insurance claims.

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Patient /Guardian

OPTOMAP RETINAL EXAM

The Optomap Retinal Exam is an enhancement to your exam that is fast, easy, and comfortable. It offers many advantages including:

- Provides an ultra-widefield view of the retina
- Is non-invasive
- Allows you to view your results with the doctor during the exam
- Provides an annual, permanent record which gives your doctor comparisons for tracking and diagnosing potential issues

Some of the first signs of diseases such as stroke, diabetes and even some cancers can be seen in your retina, often before you have other symptoms. An optomap makes it easier to see them.

- ❏ Yes, I would like to have this test to be performed today for an additional $49.00 ($29 for students)
- ❏ No, I decline Dr. Blase's recommendation to have this test performed.

Patient/Guardian: ______________________________

Dilation Option

Dilation side effects include light sensitivity and blurred vision for up to 6hrs.

**If you marked Yes for the Optomap, dilation is not needed.

- ❏ Yes
- ❏ No

Patient/Guardian: ______________________________

CONTACT LENS EXAMINATION

- ❏ **Yes**, I am interested in a contact lens examination. (Please read and sign below)
- ❏ **No**, I am not a contact lens wearer. (Proceed to next side)

A contact lens evaluation will include a contact prescription, trials, contact lens solution, and any follow up visits within 60 days of the initial exam. A contact examination that is single vision will be $45.00 and an examination that is a multifocal lens or has any astigmatism will be $60.00. Depending on your vision plan, you may be covered for the contact lens examination. Ask your technician for eligibility.

Patient/Guardian: ______________________________

Acknowledgement of Notice of Privacy Practices

The law requires that **Crossroads Vision Care** make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I have understood the terms of the Privacy Notice and that I may access it at any time by visiting www.crossroadsvisioncare.com.

Please check one of the following:

- ❏ I was presented Crossroads Vision Care's Notice of Privacy Practice and **agree** to continue my care with Crossroads Vision Care under said terms.
- ❏ I have **read** or had **explained** to me Crossroads Vision Care's Notice of Privacy Practice and **do not** wish to continue my care with Crossroads Vision Care under said terms.
- ❏ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as:

  ____

I have read and understand this form. I am signing it voluntarily.

________________________________ ________________

Patient Signature Date

Please indicate your relationship to the patient if signing as a personal **representative.

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Relationship to Patient