

*Digital RETINAL Imaging Screening
Authorization Form*

We are excited to announce that we have incorporated into our practice a new, highly sophisticated, computerized instrument that allows us to provide a more thorough medical analysis of your eyes. Our new VISUCAM RETINAL CAMERA takes photographs of your retina (the back of your eye). The procedure assists the doctor in the early detection of many disorders, including hypertension, glaucoma, diabetes, macular degeneration, retinal detachments and other vision threatening conditions. These images are stored in the computer and compared with images from future exams. This allows the doctor to observe even the smallest change from the previous exam.

We strongly recommend this procedure as part of your exam if:

- 1) You are a new patient to this office
- 2) You have never had retinal photos of your eyes
- 3) You are 65 or older
- 4) You have or have a family history of high cholesterol, elevated blood pressure or any circulatory disorder
- 5) You have or have a family history of diabetes or elevated blood sugar
- 6) You have headaches or visual disturbances suggestive of a neurological problem
- 7) You have or have a family history of elevated eye pressure or glaucoma
- 8) You have any retinal disorder such as a detachment, tear, floaters, veils, flashing lights, bleeding or macular degeneration
- 9) Your vision is not correctable to 20/20 in one or both eyes

“Screening retinal photography” is a necessary part of your eye exam if you fall into any of the above categories. The charge for this procedure is \$35.00. If pathology or an “at risk” condition is documented with the screening photos we will bill your insurance company or Medicare for a “photographic study” which requires additional photography. If your insurance company allows this study (most do), you will only be responsible for your normal co-pay or deductibles.

We are very excited about the results of this new technology and highly recommend retinal imaging as an additional test in your eye exam. MANY HEALTH PLANS WILL COVER THIS PROCEDURE.

The fee is only \$35

_____ Yes, I want this procedure

_____ No, I do not want this procedure

Signature

Print name

Date