

DATE _____

DILATION CONSENT

Dilation is important for the inspection of the periphery of the eye for the presence of tumors, retinal detachments and other conditions such as floaters, flashes or spots appearing suddenly in the vision. The need to record the use of dilating agents has become a standard on determining the thoroughness of the examination. Some vision care plans do not cover this service. Please consult the front desk if you have any questions concerning this fee.

Note: Due to the widening of the pupil, dilation will affect the comfort of many patients when reading and create light sensitivity, usually lasting approximately 4-6 hours, but may last overnight.

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made to Dr. Bradley W Fielding on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

CHECK AND SIGN BELOW:

_____ I accept Dilation

_____ I decline Dilation

SIGNATURE OF PATIENT OR AUTHORIZED AGENT

X _____