Patient's name: _____ Date: _____

Privacy Policy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices describes these uses and disclosures in detail. I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices from Burke Optometry.   _____initials

Financial Disclaimers & Liability

We will assist you with billing of your insurance, as long as accurate insurance information is provided to us. We will also attempt to verify your plan eligibility for services and/or materials before your appointment. If you have coverage through multiple vision care plans, please provide us the information necessary so we may check eligibility and obtain authorizations. *Verification of eligibility is done as a courtesy only and is not a guarantee of payment.* I authorize my plan carrier to directly pay Burke Optometry. I also authorize Burke Optometry to release any information required for payment to be made. *I understand that any outstanding balances, co-payments, co-insurances, deductibles and non-covered services are my responsibility.* Please note that returned checks are subject to a $25.00 re-deposit and reprocessing fee. Burke Optometry reserves the right to charge a $30.00 no-show fee for any appointment not canceled or rescheduled at least 24 hours in advance.

                                                                              _____initials

Refraction Fee

The testing done to determine your lens prescription is called refraction. Our refraction fee is $50.00. Vision care plans such as VSP, EyeMed, MES Vision, and Superior Vision pay the refraction fee as part of the routine eye examination coverage. Medical insurances, including Medicare, do not include routine vision benefits and *do not cover the refraction fee*.

                                                                              _____initials

Permission to market

I give permission to use my email address and/or mailing address to send notice of special events, including frame shows. Circle one: Yes   No
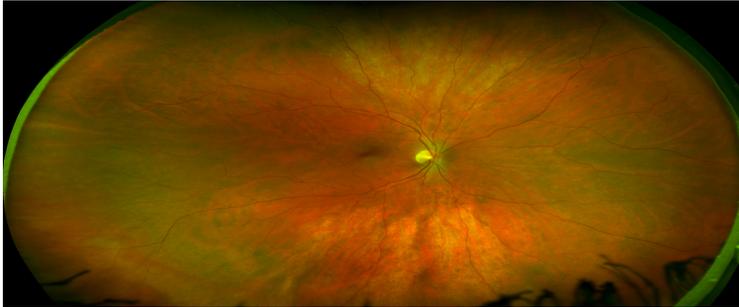
My signature below verifies that I understand this agreement.

_____

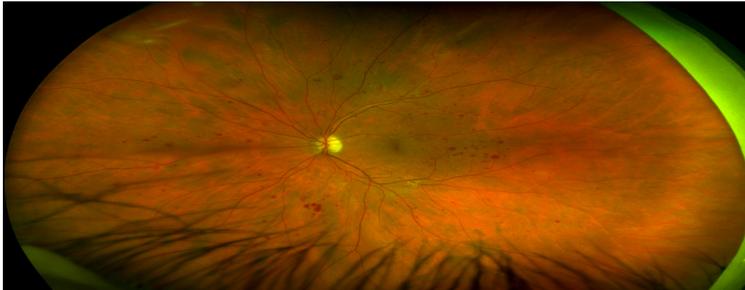Signature of patient   (or signature of parent/legal guardian, if patient is a minor)

We accept cash, personal checks, most credit cards & debit cards. We also offer Care Credit.
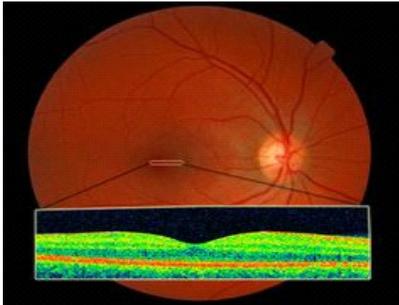
optomap®

Optomap ultra-wide image of normal, healthy eye:
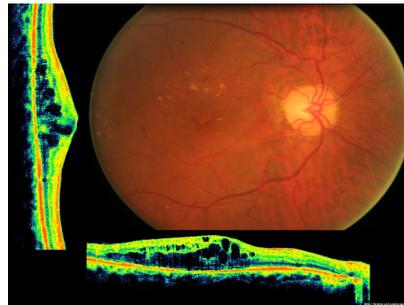

Optomap ultra-wide image, example of diabetic retinopathy:

Zeiss Cirrus OCT, Normal macula: **Zeiss Cirrus OCT, Diabetic edema:**

Digital Retinal Imaging (DRI):

Our doctors recommend the **Optomap** DRI to enhance your eye exam by providing a more comprehensive examination of the internal eye structures. The new **Optomap** provides a wide angle photographic image of the retina and usually does NOT require pupil dilation. Having this image in your medical record allows your doctor to make comparisons over time. The doctor will review the images and share the 3D view of the inside of your eye during your exam. **The doctors believe this imaging improves the quality of your eye health exam and recommend it for all patients as part of the pretest workup.**

After the age of 40, we also recommend the **Zeiss Cirrus OCT** for imaging which provides the doctor with valuable information about the layers within the central retina (macula) and the health of the optic nerve. Early detection of conditions such as macular degeneration, diabetic retinopathy and glaucoma can help maintain your vision and improve treatment options. If everything is normal, we'd like to repeat this imaging every 2-3 years. At this time, most insurances do not cover screening.

I **agree** to the Optomap retinal screening for $25 (normal fee $80)   _____ initials

I **agree** to having **both** screening images taken for $39 (normal fee for both $130)   _____ initials

I would like to discuss this with the doctor first.   _____ initials