▪ CONSENT FOR DILATING EYE DROPS WHILE UNDER THE CARE OF BVA DOCTORS

A variety of eye drops may be administered during the course of your eye examination. Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of time vision will be blurred and the degree of eyesight impairment varies from person to person. It is not possible for your doctor to predict how much or how long your vision will be affected. Driving even in low light conditions may be difficult or impossible after an examination with dilating drops, and, if possible you should not drive yourself afterwards.

Instead, we strongly suggest you make alternate arrangements for transportation after your examination. If you choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. Although uncommon, the potential for adverse reactions from eye drops does exist, such as acute angle-closure glaucoma, which may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

You hereby authorize BVA doctors and/or assistants to administer dilating eye drops or other eye drops during the course of your treatment. You understand that these eye drops are necessary to diagnose your condition. You further understand and acknowledge that you have been warned of the potential risks that dilating eye drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated or by wearing sunglasses while driving.

____ ________________________

Patient (or patient’s authorized representative) Date

Patient Name: ______________________________
DOB: ______________________________

■ **PATIENT AUTHORIZATION**
Assignment of Medicare and Insurance Benefits and Acknowledgement of Privacy Practices

I request that payment of authorized Medicare, Medigap, or any other insurance be made on my behalf to BVA Advanced Eye Care for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) , or any other insurers and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, or insured contracts, the provider agrees to accept the charge determination of the Medicare carrier or insured contracts, I am responsible for the deductible (Medicare deductible $183.00), co-insurance (or the 20% Medicare) or insurer does not pay, and for any non-covered services.

I understand I am responsible for my bill in the event Medicare or my insurer denies the claim. I authorize release of medical records to my primary care physician or any other physician associated with continuity of my care.

I authorize BVA Advanced Eye Care , its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but its not limited to, home telephone, cellular telephone, and employment telephone. I hereby grant permission and consent to BVA Advanced Eye Care, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice ot text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me. Additionally, I understand that some procedures/services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.

■ **AUTHORIZATION OF CARE**

I authorize BVA to examine me and perform such tests and procedures as are reasonable and necessary in the diagnosis and treatment of my care. If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient’s behalf.

Signature:____ Date:______________________

Representative Signature:______________________________ Date:______________________

Patient Name: ______________________________
DOB: ______________________________

▪ PATIENT RECORD OF DISCLOSURE

The HIPPA privacy rule provides individuals with the right to request a restriction on notes and disclosures of their protected health information.

Persons to whom my personal health information may be discussed and/or released:

☐ Name:______________________________Relationship:______________________Phone #:___________________

☐ Name:______________________________Relationship:______________________Phone #:___________________

☐ No one other than myself.

Your signature authorizes BVA Advanced Eye Care to disclose information about you to the person(s) indicated above. If applicable, this may include information relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

This release is valid unless revoked, in writing, and signed by you. However, such revocation will not effect disclosures made in regard to any previous authorization.

▪ NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of BVA Advance Eye Care's Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have had the opportunity to review the Notice of Privacy Practices. The HIPAA Privacy Notice can be accessed on-line at www.bva20-20.com or in the BVA office.

Patient's Signature ____ **Date** ______________

Representative's Signature ____ **Date** ______________

Relationship of Representative to patient __________________________________