HUNTLEY
EYE CARE

Patient Annual Consent Form

Welcome to Huntley Eye Care! Thank you for choosing our office to provide you with your comprehensive eye examination and all your eye care needs. Please **INITIAL in corresponding boxes** to ensure that we have your annual consent.

To protect your privacy and in respect for others, please **DO NOT USE your cellular device** while in our office.

FINANCIAL AGREEMENT

☐ I agree to assume all financial responsibilities as noted in "Financial Agreement."

If patient is a minor, guarantor (person who will be financially responsible for account) will default to parent/legal guardian accompanying patient on day of exam. Copy of agreement is available at patient's request.

Guarantor (Sign & Print, if other than patient) _____

NOTICE OF PRIVACY PRACTICES

☐ I have been presented with and understand the "Notice of Privacy Practices" of Huntley Eye Care, L.L.C. and may obtain a copy of the policy at my request.

iWellnes Screening

Due to the social distancing guidelines of COVID-19, all dilation will be deferred since the procedure will put the patient and doctor at closer than 6 feet of each other, unless the patient is experiencing ocular symptoms that warrant the procedure, such as flashes, floaters, etc. ***Therefore, it is now highly recommended for the patient to complete our iWellness screening for the doctor to have a more thorough assessment of the patient's ocular health.*** *This procedure will capture a retinal image of the patients eyes and allow for a scan of the retinal tissues below what is normally visible to the eye. The procedure is safe and harmless to the eyes and there is only a copayment of $44 for this procedure.*

☐ I **AGREE** to the iWellness Screening and decline the dilation at this time. I understand the benefits and risks involved.

☐ I **DECLINE** the iWellness Screening at this time and wish to schedule a dilation for a future date. Additional fee for office visit will apply.

CORNEAL AND CONTACT LENS EVAULATION

Contact lenses are FDA-regulated medical devices. A corneal and contact lens evaluation is necessary to monitor changes to the health of your eyes from utilizing these devices. There is an increased risk of infection and/or corneal ulcers that can lead to loss of vision with contact lens wear. Therefore, an annual evaluation is necessary if you would like to continue wearing, replacing, and/or reordering your contact lenses. *The evaluation includes the initial evaluation, the use of diagnostic lenses, and any contact lens prescription–related follow-up visits within 60 days.* ***Any office visits greater than 60 days or any office visits within 60 days that is not contact lens prescription-related (i.e. red eye) will be charged a separate office visit fee.***

☐ I **AGREE** to a corneal and contact lens evaluation. My vision plan and/or medical insurance may or may not cover this evaluation. I agree to pay for the evaluation at time of service. **I understand the corneal and contact lens evaluation fee is a professional service and is non-refundable,** even if I decide not to go forth with contact lens wear after the diagnostic lens trial period.

☐ I **DECLINE** a corneal and contact lens evaluation. I understand that if my contact lens prescription is expired I will not be able to order any more contact lenses without a corneal and contact lens evaluation.

PLEASE COMPLETE NEXT PAGE

COVID-19 SCREENING

Yes	No	
☐	☐	Within the last **30 days** have you been diagnosed with COVID-19?
		If yes, Date of positive test: _____ Date of negative retest:_____
		Within the last **14 days** have you experienced any of the following symptoms:
☐	☐	Fever
☐	☐	Cough
☐	☐	Shortness of breath or difficulty breathing
☐	☐	Chills
☐	☐	Repeated shaking with chills
☐	☐	Muscle pain
☐	☐	Sore throat
☐	☐	New loss of taste or smell
☐	☐	Have you traveled in the last 14 days
☐	☐	Have you or a member of your household had close contact with or cared for someone diagnosed with COVID-19 in the last 14 days?
☐	☐	Have you or a member of your household had close contact with or cared for someone with a presumptive positive case of COVID-19 in the last 14 days?
☐	☐	Has anyone in your household been asked or required to quarantine based on contact with a person who has a confirmed or presumptive positive COVID-19 test result or diagnosis, or have you been asked to quarantine?

OFFICE USE ONLY
Non-Contact Forehead Temperature: _____

PATIENT NAME: FIRST _____ LAST _____ DATE OF BIRTH: _____

Signature _____ **Date** _____

Relationship to patient (if patient is a minor) _____