PATIENT CONTACT INFORMATION

Patient Email Address: _____
In case of emergency: Contact Person_____ Phone _____
Whom may we thank for referring you to our office today? _____

Notice of Privacy Practices

We are required by federal and state laws to maintain the privacy of your health information. However, we may disclose your information to carry our treatment, payment, and healthcare operations. By signing below, I acknowledge that I have received/read the Notice of Privacy Practices and authorize the release of my health information required by the laws under the conditions described in the Notice of Privacy Practices.

optomap®
ultra-widefield retinal imaging

Dr.Washington now performs the optomap® retinal scan on all of her patients during the annual eye examination. The optomap will allow Dr. Washington to capture an image of the back of your eye where potential vision threatening diseases can be found. This includes **diabetes, glaucoma, certain types of cancer, retinal tears, retinal detachments and cardiovascular issues.**

The optomap is a vital tool in assessing the health of the retina in all patients types including our pediatric patients.

As part of your pre-test work up, we will capture optomap® images for review with Dr. Washington during your examination today. **There will be a $39 co-pay with your insurance**.

I have read and understand this document in its entirety:

Sign: _____ Date:_____