

Karl Czirr, O.D.

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Screening Visual Fields Examination and Retinal Photos

Our office uses several highly sophisticated, computerized instruments which allow us to provide a more thorough medical analysis of your eyes. The **OCULUS EASYFIELD** electronically measures retinal function and sensitivity to light. The **KOWA DIGITAL RETINAL CAMERA** provides a stable, wide view of the retina which can show minor changes to the retina which may not be seen otherwise. The Doctor will discuss the findings with you.

Combined with our thorough eye exams, these instruments can assist in the early detection of many disorders, including brain tumors, glaucoma, diabetic retinopathy and retinal detachments. ***We strongly recommend that all of our patients receive the screening versions of these tests.*** It is especially important for people who have:

- 1- Headaches
- 2- See spots and/or flashes
- 3- A history of diabetes
- 4- Circulatory/high blood pressure problems
- 5- A strong eyeglass prescription
- 6- Reached the age of 35
- 7- Have not had the test in over 2 years

There is an additional charge of **\$16.00** for both screening exams. The cost of this screening is usually not covered by insurance. If this screening shows a possible problem, a more detailed version of these tests will be required. These additional tests usually are covered by insurance. Please check the appropriate box below.

- I **DO** want the screening visual field exam and retinal photograph
- I **DO NOT** want a printout of the retinal photograph (I understand it is no extra charge to me.)
- I **DO NOT** want the screening visual field exam or retinal photograph

Patient Consent

Consent is very important. By signing below you are giving Dr. Czirr your consent for treatment, and if necessary, the sharing of your Personal Health Information (PHI), as needed for continuation of your health care. Dr. Czirr cannot provide treatment without your consent. Please refer to the Statement of Privacy Practices sheet to illustrate when the Doctor may need to disclose your PHI. You as the patient have the right to request restrictions on how the Doctor uses or discloses PHI to carry out treatment, payment and other healthcare operations. However, the Doctor is not required to agree to requested restrictions and will inform you of disagreements. Patient has the right to revoke the consent in writing, except to the extent that the Doctor has taken action in reliance upon the consent.

I have read, understand, and agree to the Personal Health Information sharing practices on the Notice of Privacy Practices, found on the clipboard.

By circling YES below, I authorize Dr. Czirr and staff to freely discuss my care as needed but **ONLY** with those authorized. Not circling anything indicates nobody is authorized to receive your PHI.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	OR	NO
SPOUSE ONLY	YES	OR	NO
OTHER (PLEASE SPECIFY)	YES	OR	NO

Patients Signature _____ **Date** _____