

# Retinal Health Screening Tests

Your annual eye exam at Piedmont Eyecare Associates includes an examination of the back of your eye. This examination is important in the early detection of disorders which may be harmful to your vision, including Glaucoma, Hypertension, Diabetes, and Macular Degeneration. We recommend two screening tests at your annual eye examination. These tests are not covered by insurance plans because they are preventive in nature, but we keep the cost as low as possible.

**DIGITAL RETINAL PHOTOGRAPHY** - Recommended for all patients annually **\$36**

This technology combines retinal photography with computerized imaging to allow instant viewing of the retina and optic nerve in great detail. The benefits to Digital Retinal Photography are:

- Early diagnosis of abnormal conditions
- Maintain a digital record of the back of your eye
- No light sensitivity
- No stinging
- No drops

**MACULAR PIGMENT DENSITY TEST** - Recommended for patients age 30 and above **\$25**

This measures your risk for developing macular degeneration, a leading cause of blindness in the United States.

We encourage you to take advantage of both tests for a combination value of **\$48**

- Combination Value \$48**
- Retinal Photography only \$36**
- Macular Pigment Density Test only \$25**
- I do not wish to have any screening tests**

## DILATION:

Dilation involves opening your Pupils with drops so that the doctor can look at the back of your eye.

If you have the screening retinal photography above, it is generally adequate.

Dilation has the following side effects:

- Sensitivity to light
- Blurry vision
- Possible stinging
- Requires eye drops

I prefer to **DECLINE** Dilation \* \_\_\_\_\_

***\*If you are 65 or older and/or diabetic you will be dilated to meet insurance health requirements.***

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By signing, I also understand that Piedmont Eyecare Associates, O.D. is required by law to protect my privacy and health information, as stated in the *Notice of Privacy Practices*. A copy of this is available at the front desk.

Patient name (Print) \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Your signature will allow Piedmont EyeCare to file the insurance you provided for your exam today. Payment from my insurance is to be paid directly to Piedmont EyeCare. I understand that my insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quote to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_