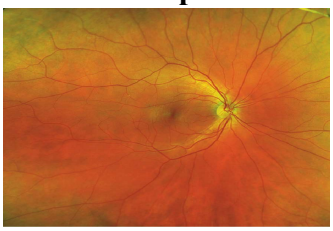
MV ACCT #

Wide Field Retinal Photography

Yearly Retinal Imaging is one of the most effective ways to closely monitor the health of the eye and can aid in early detection of eye disease. We now offer WIDE FIELD Retinal Photography, which allows for an even greater view back into the eye. This Wide Field Retinal Screening may even be used to replace routine eye dilation in many patients. (For some eye diseases, eye dilation may still be required/recommended by the doctor).

Our doctors strongly recommend that ALL patients have WIDE FIELD RETINAL SCREENING performed.



It is especially important for people who are/are concerned for or have/have a family history of:

* New Patients
* Diabetes
* Glaucoma
* Spots/Light in Vision
* High blood pressure
* Macular degeneration
* Sudden Vision Changes
* High cholesterol
* Retinal Disorders

The cost of Retinal Screening is **$36.00** and is **not** covered by insurance. **Payment is due day of services.**

_____ YES, I DO want the Wide Field Retinal Screening performed.

_____ NO, I DO NOT want the Wide Field Retinal Screening performed.

(NOTE: If you have known internal eye disease, we will take photographs, if necessary, and file this service to your Medical Insurance)

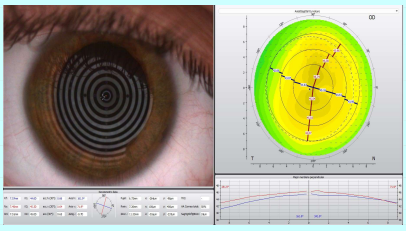
PRINT NAME _____Signature_____ Date_____

Contact Lens Exam

In Addition To A Comprehensive Exam, We Perform A CORNEAL EVALUATION On Every Contact Lens Wearer

This evaluation is a topography scan of the cornea & an assessment of the tear film of the eyes. This test is will be performed yearly to examine the current state of your corneas & your eyes' ability to continue to wear contact lenses.

Corneal Evaluation is necessary for all contact wearers prior to prescribing any lenses.
The cost is **$35.00** and is **not covered by insurance.**
Payment is due day services performed.



Note* Additional fees for refits ($49-99) or new trainings ($89-205) may apply.
Not everyone can successfully wear contacts. NO REFUNDS WILL BE ISSUED.

_____ YES, I DO want to wear contacts & have the evaluation performed

_____ NO, I DO NOT want the evaluation performed. I understand by declining I will not be prescribed contact lenses & will also be unable to order lenses

PRINT NAME _____Signature_____ Date_____