

**AUTHORIZATION FORM**

Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SSN or Insurance ID Number \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance Name \_\_\_\_\_ Employer \_\_\_\_\_

Group or Plan Number \_\_\_\_\_ Other Insurance Coverage \_\_\_\_\_

I authorize Wells Branch Vision Care PA to release any information necessary to process insurance claims. I authorize payment of benefits to this provider for services and materials that have been supplied. **I understand that I am ultimately responsible for any unpaid claims and that this authorization is valid until such time that I terminate it in writing.**

Print Patient Name \_\_\_\_\_ Patient DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Responsible Party Signature \_\_\_\_\_ Today's date \_\_\_\_\_

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We are concerned about the health of your eyes. Problems such as glaucoma, macular degeneration, retinal detachments and diabetes are all conditions that can lead to blindness but often have no symptoms. A wide-angle view of the retina provides the best chance of detecting these conditions. The Optomap allows us to capture a digital image of your retina. It is quick and requires no eye drops. **There is an additional \$29 charge for Optomap that may not be covered by your insurance company.** Dilation also allows a wide-angle view, but will cause blurriness and sensitivity that can last 3-4 hours. There is no additional charge for dilation.

You may opt to have neither test with the understanding that there may be conditions that we will not be able to detect with a routine exam.

**Please sign on the appropriate line to indicate your preference.**

I choose Optomap. \_\_\_\_\_ Date \_\_\_\_\_  
signature

I would prefer to be dilated. \_\_\_\_\_ Date \_\_\_\_\_  
signature

I do not wish to have Optomap or dilation at this time. \_\_\_\_\_ Date \_\_\_\_\_  
signature