# VISION SOURCE TULSA

A MEMBER OF VISION SOURCE®

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**Privacy & Financial Agreement:**
I consent to the use and disclosure of my child's health information for purposes of treatment, payment, and health care operations. I understand that if our insurance does not cover the charges for services and/or materials, we are responsible for the amount due.

**Contact Lens Agreement If Applicable:**
I understand that a contact lens fitting is not part of a routine vision examination. This is a separate service and therefore there is an additional cost. This is nonrefundable and due at the time of service. The fee will be determined by the type of correction required, such as spherical, toric, multifocal or specialty contacts which range from $75-$105. Some vision insurance plans may contribute to this fitting fee while others do not.

**Retinal Imaging (Optomap)**
This is a highly recommended image that captures up to 82% of the retina. These images help the doctors assess the health of your eyes and check for conditions inducing macular degeneration, glaucoma, and retinal detachments. These problems can threaten vision without warning or symptoms. Additional health issues that can be detected are diabetes, hypertension, heart disease, some cancers, and auto-immune disorders. This image is $49 with some insurances covering a portion of the fee. It is optional for minors under the age of 18.

☐ I consent for my child to have a retinal image taken and understand that we will be responsible for the fee

☐ I would like to decline this image for my child at this time

Please email this form to our office prior to the exam if possible at contactus.vstulsa@gmail.com or bring it in person at the scheduled time.

| *Patient Name* | *Patient Date of Birth* | *Date* |
|---|---|---|

| *Parent/Guardian Name (if minor)* | *Parent/Guardian Signature* | *Date* |
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