Bruening EYE SPECIALISTS
101 Tower Road Suite 300 ~ Dakota Dunes, SD 57049

Patient Name _____ Account #:_____

Informed Consent for Dilating Eye Drops
Dilating drops are used to dilate or enlarge the pupil of the eye to allow the ophthalmologist/optometrist to get a comprehensive view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright light bothersome. It is not possible for your ophthalmologist/optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Bruening Eye Specialists is not responsible for incidents related to dilation that occurs outside the clinic. If you choose not to have dilation, please notify your nurse at the beginning of your exam.

Services Rendered
Although you may be scheduled for a particular type of visit, the provider may deem it in your best interest to address other matters of concern which were not originally planned at the time the appointment was scheduled. This may result in another charge billed to your insurance carrier and possibly an insurance/patient cost sharing (deductibles, co-payments and/or co-insurance). This is a widely acceptable industry standard of care.

Refractions
A refraction is the test performed to evaluate your best corrected vision used to determine your ocular health status or to prescribe spectacles and/or contact lenses. Refractions are not covered by Medicare or many other commercial insurance companies. However, as a courtesy to our patients, we will bill your insurance company in case it is a covered benefit. If you choose not to have a refraction done, please notify your nurse at the beginning of your exam.

Assignment of Benefits
I request that payment of authorized benefits be made to Bruening Eye Specialists for any services furnished by the doctor. I authorize any information needed to determine benefits/process the claim be released to my insurance company. I understand that I am financially responsible for charges not covered.

HIPPA/HITECH Consent
My signature acknowledges that I am aware that, upon my request, I will receive a copy of the *Bruening Eye Specialists Notice of Privacy Practices*. I understand that it is my right to receive this information and it is in my best interest to read and inquire about any privacy issues or concerns that I may have.

I have read and understand the above.

Signature _____ Date: _____

Relationship to patient (if patient is unable to sign) _____