



## Optomap Ultra-Widefield Imaging Technology

At **Refocus Modern Eyecare**, we pride ourselves in providing our patients with the best possible standard of care. Because of this, our doctors strongly recommend that all patients have an Optomap® Retinal Exam. This non-invasive procedure allows your doctor to see a much broader and more detailed view of the retina than is possible with conventional methods such as dilation. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. Our doctors believe that the Optomap® Retinal Exam is an essential part of your comprehensive eye exam and offer it to all patients every year.

This imaging device allows the doctor to detect retinal abnormalities, glaucoma, macular degeneration as well as other health conditions such as diabetes, high blood pressure, cholesterol, tumors, and other life threatening diseases.

### Our Doctors Recommend Optomap for the Following Reasons:

- The ability to show you your retinal images today, during your exam
- An in-depth view of nearly the entire retina (where diseases can start).
- A permanent record for your medical records, which gives your doctor a comparison for diagnosing and tracking retinal eye disease annually.

### Optomap Retinal Imaging is:

- Fast, easy, comfortable and patient friendly.
- Eliminates the need to be dilated (in most cases).

\*Please Note: The Optomap® Retinal Screening Exam is not covered under your basic health plan, meaning that you are responsible for the charges. Our fee for the retinal screening, measurement and interpretation is **\$39.00**. We will collect this fee along with your co-payment and deductibles at the end of your visit.

Please select one:

- I elect to have an Optomap Digital Retinal Image of my retina
- I do not want an Optomap Retinal Image; I am willing to be dilated (\$50 fee).

Print Patient's Name: \_\_\_\_\_

Print Legal Guardian's Name (if applicable): \_\_\_\_\_

Signature of Patient or Guarantor: \_\_\_\_\_

Date: \_\_\_\_\_