PUZIO
eyecare associates

CONSENT TO TREAT WITHOUT PARENT/GUARDIAN

PATIENT INFORMATION

Name of patient _____
DOB of patient _____
Name of insurance company and ID number _____
Parent/guardian name, relationship to the patient and contact information
_____

Name of primary care doctor_____
Please list any known allergies_____
Is the patient currently taking any medication? _____
If yes, please list all medications_____
Please list any medical problems or conditions requiring special attention
_____
Is there any other information the Doctor should be aware of
_____

OPTOMAP

The Doctors of Puzio Eye Care highly recommend that patients receive an Optomap during their visit. The Optomap is a test that takes a panoramic photo of a patient's retina, enabling the Doctors to observe a patient's retina health. The Optomap is non-invasive and painless and in many cases, can be used as an alternative to dilation of the eyes. The out-of-pocket cost of an Optomap is $38.00. Please check the below box to approve of the Optomap test for the person listed below.

☐ Please check to approve the Optomap Test

DILATION

Should you choose not to approve of the Optomap, or if something is noticed by the Doctors after the Optomap such that dilation of the eyes is deemed necessary, it is left to the discretion of the Doctors to dilate the eyes of the person listed below. Dilation involves instilling eye drops in the eyes that temporarily increase the size of the pupil (the black center of the eye), enabling the Doctors to gain a more detailed view of the inside of the eye. These drops can cause temporary light sensitivity and blurred vision that goes away in a few hours and without side effects.

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CONSENT

I hereby provide consent to authorize the Doctors and Technicians of Puzio Eye Care Associates to medically treat the person listed below without my presence, including examination, medical diagnosis, tests, and treatment, including dilation of the eyes.

I understand that administration of contact lenses will not occur without a parent/ guardian present.

I understand that if the Doctor does not have sufficient information regarding the patient for their appointment or if there is any issue related to the treatment of the patient where further consent may be necessary, Puzio Eye Care Associates reserves the right to reschedule the appointment.

I understand that I am financially responsible for any insurance co-pay or other fees associated with the appointment, such as the cost of the OPTOMAP test, outlined above.

This authorization shall be valid for the visit commencing on the date specified below and shall continue until otherwise revoked by me or another parent/ guardian of the patient. Should I choose to revoke this consent, I can do so with written notice to Puzio Eye Care Associates.

NAME OF PARENT/GUARDIAN	CHILD/PERSON AND RELATIONSHIP
SIGNATURE OF PARENT/GUARDIAN	DATE
DATE OF VISIT	PATIENTS DATE OF BIRTH