

Dear Patient,

Our Xenia office utilizes a new technology to provide you with a more thorough medical eye evaluation. This technology is digital retinal imaging, which takes photographs of the retina (the back of the eye). This procedure assists the doctor in early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. This technology also serves to permanently document the current state of your eye health. The photographs will be stored in the computer and compared with the results of future examinations of photographs. This allows the doctor to observe even the smallest amount of change from the previous photograph or examination.

The procedure, which only takes approximately five minutes, will be performed and billed to your medical insurance company should you have a medical eye condition, such as glaucoma, diabetic retinopathy, macular degeneration, choroidal nevi, retinal degeneration, etc. However, Dr. Florkey and Dr. Wheeler strongly recommend that all patients have this procedure performed at least once. It is especially important for those who have:

1. headaches
2. see spots (floaters) and/or flashes of light
3. family history of glaucoma
4. personal or family history of high blood pressure
5. family history of macular degeneration
6. use of certain systemic medications (i.e. plaquenil, tamoxifen, etc.)

The typical fee for this procedure is \$71.00. However, we have chosen to provide this procedure at a reduced cost of \$55.00, which will be billed to your medical insurance if the testing finds that you have a medical eye condition. If the procedure is performed just to obtain a screening photograph we will reduce the cost to \$35.00, if paid for on the day the photograph is taken. Should your insurance company deny payment of the procedure, you will be billed \$35.00.

Please check the appropriate line below and sign at the bottom.

_____ I do not want retinal photography performed.

_____ I do want retinal photography performed.

_____ I do want the retinal photography performed but please schedule for another day.

Family doctor name and address _____

Signature _____