Jackson and Lujan
EYE CARE CENTER

Dilation of the Pupils (Dilation adds about 20-30 minutes to the examination)

We at Jackson and Lujan Eyecare strongly recommend that all patients be dilated as part of a comprehensive eye examination. **Routine dilation is especially recommended for patients with diabetes, high blood pressure, high myopia (near-sightedness), symptoms of flashes/floaters, glaucoma or family history of glaucoma.** Dilation involves placing drops in your eyes to enlarge the pupil. This provides a much wider view inside the eye. Side effects of the dilation are increased sensitivity to light, slight blurring of distance vision and inability to focus up close. Some patients feel uncomfortable driving afterwards. These symptoms last from 1-4 hours depending on the patient. There is no additional fee for this procedure.

☐ I consent to have my eyes dilated.

☐ I understand the importance of the dilation, yet I do not wish to have it performed at this time.

Comprehensive Eye Screening (takes about 10 minutes and does not affect your ability to drive)

This screening includes a high resolution photograph of your retina along with a scan that takes a deeper look into the back of the eye that cannot be seen by the naked eye (similar to an MRI without radiation). **This screening is particularly recommended for those with diabetes, high blood pressure, macular changes or other history of eye disease**. It is also a good idea for those with a family history of eye disease such as glaucoma. While this does not take the place of a dilated examination, it is a good alternative for a more in depth evaluation for those who are unable to dilate today. These procedures add to our ability to detect potential eye disease earlier and prevent vision loss. The fee for this screening is $50.

☐ I would like the comprehensive retinal screening.

☐ I do not want the comprehensive retinal screening.

_____
Printed Patient Name

_____ _____
Patient or Guardian Signature Date

JACKSON AND LUJAN EYECARE CENTER
4400 FREDERICKSBURG ROAD, STE 107
SAN ANTONIO, TEXAS 78201
210-737-1926 PHONE/ 210-737-2621 FAX

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

In signing this HIPAA Patient Acknowledgement Form, I consent to allow Jackson and Lujan to summon me from the reception area by calling out my first and last name.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO MY HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By sharing my Cell phone, Home phone, Address, Work phone and/or email, I am giving Jackson and Lujan Eyecare permission to contact me via one of these methods to relay information concerning my glasses or contacts, special services or events, appointment and yearly exam reminders. These contact methods may also be used to relay treatment information, billing information or information about my health. If I do not wish to be contacted by one of these methods, I will not give that contact information to Jackson and Lujan Eyecare.

By signing below, I acknowledge that I was given the opportunity to read a copy of the current effective Notice of Privacy Practices for Jackson and Lujan Eyecare. My signature will also serve as a Personal Health Information document that will allow my health information to be sent to another doctor/healthcare facility in the event that I need a referral today or in the future. I also consent to have medical health information sent to my health/vision insurance.

In signing this HIPAA Patient Acknowledgement Form, I acknowledge and authorize, that this office may recommend products or services to promote your improved health. Under the current HIPAA laws, if Jackson and Lujan Eyecare receives any remuneration for these products or services, this office will provide me with this information and obtain my consent first.

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient/Guardian of Patient

_____ _____

Legal Representative/ Guardian Relationship of Legal Representative/Guardian

Date: _____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because (please describe) _____

Signature of Privacy Officer _____

Updated 12/4/2020