Omar Munshi, O.D.
25 South Street
Morristown, NJ 07960
Phone: 973-538-5287
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Patient Name _____ Date of Birth_____

DILATION CONSENT

A dilated retinal examination, or dilation, is a routine procedure in which drops are used to dilate the pupils (make them larger). This highly recommended test allows the doctor to examine the peripheral retina, which cannot be seen without dilating the pupils. It is important to evaluate the peripheral retina and the optic nerves for the presence of tumors, retinal tears or detachments, glaucoma, macular degeneration, and other types of diseases which may or may not have any symptoms. Dilation is even more critical for those who are diabetic, have high blood pressure, wear a strong eyeglass prescription or have a family history of eye diseases. Failure to perform dilations may lead to a vision threating condition going undetected. The eye drops used for dilation take full effect within 15-20 minutes and depending on the individual may take 4-6 hours for vision to return to normal function. Because of the expected blurry vision and light sensitivity, it is not recommended to drive after the exam and if you must be outside, tinted glasses with UV protection is required.

Please initial <u>one</u> of the following:

_____ **I ACCEPT** dilation to be done during my examination today.

_____ **I would like to RESCHEDULE** the dilation for another visit.

_____ **I DECLINE** the dilation today and release Dr. Omar Munshi, O.D., the examining doctor from any liability as a result of not having this test performed.

NOTICE OF PRIVACY PRACTICES/HIPAA

Please initial:

_____ I have received, read, and understand the ***Notice of Privacy Practices.*** I understand I may request a copy for my own records.

Permission To Release Your Sensitive Information*:*
I, _____, give permission for Dr. Omar Munshi, OD, and staff to speak with the following people about my protected health information (including today's appointment, billing information, etc.):

Name: _____ Relation: _____

This consent will remain in effect until it is revoked in writing.

PROVIDER SERVICES

Please initial:

_____ I understand the provider is **out-of-network** and is not responsible to submit a claim to my insurance. It is my responsibility to understand my individual Insurance policy and out-of-network coverage. I am responsible for payment in full at the time of service.

Signature: _____ Date: _____