Fisher-Swale-Nicholson Eye Center
We help you see your best.
with
Solutions In Sight
Laser and Surgery Suite
815-932-2020 • 352 Brown Blvd, Bourbonnais, IL 60914 • fisherswale.com

Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the eye doctor to get a better view of the inside of your eye for diagnosis reasons. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your eye doctor to predict how much your vision will be affected. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize doctors at Fisher-Swale-Nicholson Eye Center and/or such assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary for diagnosis. _____ patient initials

Refraction

The refraction test is performed as part of a normal eye examination to determine whether an individual has normal vision. (During this process, the eye doctor will ask you "Which is better… one or two?") It is also used to determine the prescription for eyeglasses or contact lenses. Medicare, and many other major insurance companies, have separated the refraction test from the rest of the eye examination. Instead of covering the refraction, these insurances require that the physicians themselves collect the refraction fee as a non-covered, but billable service. Some vision plans and medical insurances may cover the refraction fee, but most do not. The refraction fee is due at the time of the visit and is currently $45.00. (Subject to change) _____patient initials

Insurance/Payment

I request that payment of Medicare and/or insurance benefits be made directly to Fisher-Swale-Nicholson Eye Center for any services rendered. I understand it is my responsibility to provide complete, correct and current insurance information to allow for timely filing of insurance claims. I authorize the release of medical information about me needed to determine payable benefits for related services to my insurance carrier(s). I also understand that I am ultimately responsible for payment of services.

Patient : D.O.B.
Patient's/Guardian's signature: Date: