Schoonover Eye Care, P.C.
Dr. Rebecca Schoonover
240 Main Street | Peckville, PA 18452
570-489-8733 (phone) | 570-489-8703 (fax)

***** PUPIL DILATION *****

Pupil Dilation is a recommended part of our complete eye examination. It allows the doctor to examine the retina more thoroughly. Some retinal diseases can only be detected with dilation. It is especially important for patients with diabetes, high blood pressure, highly near sighted, patients experiencing dark spots or flashes of light in their vision or unexplained vision loss. The side effects of dilation include increased sensitivity to light and reduction in near focusing ability. Distance vision is usually not significantly affected so you should be able to drive. If you do not have sunglasses with you, they will be provided. Please ask if you are not given sunglasses. The effects of dilation last from 4 to 6 hours. If you have any questions, please ask the optometrist. There may be an additional fee of $20.00 for this procedure.

☐ I agree to have my eyes dilated.

☐ Although it is in my best interest, I decline to have my eyes dilated.

☐ I agree to have my eye dilated, but at another visit (defer).

***** AUTOMATED VISUAL FIELD *****

We recommend an automated visual field screening at your visit with us today. This is an additional test that will allow us to evaluate you for subtle losses of vision and/or retinal or neurological problems that can not be detected in any other way during a routine examination. This test will take an additional 5 minutes and the cost is $15.00.

☐ I agree to have a visual field test today.

☐ Although it is in my best interest, I decline to have visual field test today.

*****FEES & FINANCIAL AGREEMENT *****

We reserve the right to charge a $50.00 fee for chronic no shows and cancellations without prior 24 hour notice. This fee covers only a portion of the overhead, which still must be paid whether or not you are present. Once an appointment is made, please remember this time is reserved for you. I am responsible for payment of my insurance copays and deductibles upon my visit. I am also responsible for any costs my insurance does not cover. A $15.00 service fee will be added to any balance not paid within 30 days and may be turned in to collections.

☐ I agree to the fees + financial agreement.

Patient/Parent Signature: _____ Date: _____

Office Employee Signature: _____ Date: _____