PAMELA GOLCHET, MD
DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES OF THE RETINA & VITREOUS

GENERAL CONSENTS

1. CONSENT TO TREAT

I, the undersigned, voluntarily consent to and authorize VISIONARY RETINA CENTER (VRC) through its physician, employees and/or agents to provide such medical care and examinations on a continuing basis and to administer such routine diagnostic, radiologic, and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care, and treatment, in the judgment of my VRC physician, including, but not limited to, collecting and testing of bodily fluid, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

I consent to pharmacologic dilation of my eyes by the use of eye drops. I understand that this is a very commonly performed step in ophthalmic examinations but that there are uncommon but potentially serious side effects. These may include, but are not limited to, angle closure and glaucoma, headache, cardiac arrhythmia (usually temporary if it occurs), and hypopnea. IF I AM PREGNANT OR THINK I MIGHT BE PREGNANT, I WILL NOTIFY THE STAFF MEMBER OR PHYSICIAN IN PRIVACY BEFORE DILATION DROPS ARE INSTILLED IN MY EYES. While dilation drops are likely to be generally safe during pregnancy due to the small quantity and route of administration, extra precautions are taken during pregnancy to minimize and/or delay exposure.

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 ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, we recommend that you make arrangements not to drive yourself.

2. CONSENT FOR SECURITY CAMERA RECORDING IN OFFICE AND EXAM ROOMS

I hereby give my consent for Visionary Retina Center to install and operate security cameras in its office and exam rooms for the purposes of enhancing the safety and security of its patients, staff, and property. I understand that the security cameras may capture my image and voice during my visits to the healthcare provider's office.

I acknowledge that Visionary Retina Center will implement reasonable and appropriate administrative, physical, and technical safeguards to protect the privacy and security of my protected health information (PHI), as required by the Health Insurance Portability and

Accountability Act of 1996 (HIPAA) and its implementing regulations. I understand that the security cameras will only be used for the following purposes:

1. To monitor the healthcare provider's office and exam rooms for security purposes.
2. To prevent and deter criminal activity, such as theft, violence, or vandalism.
3. To investigate and respond to any incidents or complaints that may arise in the healthcare provider's office or exam rooms.

3. CONSENT TO ACCESS ELECTRONIC PRESCRIPTION INFORMATION

I hereby authorize VRC to view my external electronic prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefits managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIB, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my VRC medical record.

4. CONSENT REGARDING PHONE MESSAGES (please check all that apply)

____ I authorize you to leave a message on my home or cell number using the doctor's/practice name regarding appointments.

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize you to leave a message with anyone who answers the phone.

____ Messages may only be left with: _____

5. CONSENT TO TEXT

I consent to receive text messages related to my relationship with Visionary Retina Center, including updates related to my visits, MyPatientVisit portal, my account and registration forms, billing notifications, and care management. I understand that texting is not a secure communication method, as unencrypted messages could be intercepted. I understand that I can opt out of SMS messages by texting STOP to any text received from Visionary Retina Center. My opt-out request will generate one final message confirming that I have been unsubscribed. I will no longer receive SMS messages. If I want to join again, I can text JOIN and I will be subscribed again. If I need help I can text HELP or I can call Visionary Retina Center at 818-797-1711 or email admin@visionaryretina.com for further assistance. I understand that carriers are not liable for delayed or undelivered messages. I understand that message and data rates may apply for any messages sent to me from Visionary Retina Center and to Visionary Retina Center from me. I understand that message frequency may vary.

6. CONSENT TO EMAIL

I consent to have updates related to my visits, MyPatientVisit portal, my account and registration forms, billing notifications, and care management sent to me via email with the understanding that I may opt out at any time. I understand that if I email Visionary Retina Center physicians and others involved in my care, that I am providing consent for them to respond to me. I understand that email is not a secure communication method as unencrypted messages could be intercepted.

7. CONSENT TO PHOTOGRAPH AND USE IN MEDICAL RECORDS

I hereby authorize and consent to the taking of photographs or pictures of me by VRC and its agents or employees, and the use and storage of such photographs for identification purposes and as part of my medical record.

I hereby release VRC, its staff, agents and employees from all liability related to the making, storage and use of such photographs for identification purposes as part of my medical record.

8. CONSENT TO OUTSIDE PROVIDERS

You understand and agree that if your insurance company requires you to have a referral for service provided by out-of-network providers, you are responsible for obtaining this. The physician at VRC may refer you to providers that are out of network for you. If you desire to be referred only to in-network providers, then you may contact your insurance company for a list of active in-network providers for the relevant service, and we would be happy to help you select from within that list.

I hereby agree to and give my consent to the following items described above:

- Consent To Treat
- Consent for Security Camera Recording in Office and Exam Rooms
- Consent to Access Electronic Prescription Information
- Consent Regarding Phone Messages
- Consent to Text
- Consent to Email
- Consent to Photograph and Use in Medical Records
- Referral to Outside Providers

_____	_____	_____
Patient Name	Patient Signature	Date

_____	_____
Signature of Authorized Representative	Date

_____	_____
Print Name of Authorized Representative	Relationship to Patient/Authority to Sign for Patient