



CONSENT FOR ADDITIONAL TESTING WHILE UNDER THE CARE OF OKLAHOMA MEDICAL EYE GROUP

Your doctor may recommend additional testing to further examine and/or diagnose, including, but not limited to: Fundus Photos, Optical Coherence Tomography (OCT), Pachymetry, Tear Lab, LipiView, External Photography, Visual Field, Visual Evoked Potential (VEP), and Manifest Refraction. By signing this consent, you understand the tests may not be covered or considered medically necessary by your insurance carrier(s), even though approved by other insurances.

<u>Test Type:</u>	<u>Cost:</u>
OCT	\$75.00
Pachymetry	\$37.00
Visual Field	\$126.00
Manifest Refraction	\$45.00
Fundus Photos	\$95.00

I understand that my insurance may or may not approve payment of the above mentioned tests. If my insurance **does not** pay for the tests, I am responsible for any remaining balance or full payment.

I authorize OMEG to perform testing and/or procedures recommended necessary in the diagnosis and treatment of my care. If I am not the patient, I certify that I am signing on behalf of the patient, as a legal, authorized representative of the patient.

Patient's Signature

Date

Authorized Patient Representative

Date

Relationship to the Patient

Date