Consent to General Evaluation and Treatment

I voluntarily consent to receive eye care services at Northwest Eye Clinic from the clinic's physicians and clinical staff, including ophthalmologists, optometrists, residents, fellows, and trained technicians/assistants under appropriate supervision. This includes, as judged necessary by my eye care provider: Medical and surgical evaluation of my eyes, vision, and related health conditions.

Diagnostic testing, such as refraction, visual fields, OCT, fundus photography, ultrasound, topography, and other tests.

Use of eye drops for diagnostic or therapeutic purposes, including dilating, anesthetic, and pressure-lowering drops.

Minor in-clinic procedures (that do not involve incisions, excisions, or sutures), such as removal of superficial foreign bodies, punctal plug placement or removal, eyelash epilation, corneal surface debridement, and pressure checks.

I understand that separate procedure specific informed consent will be obtained for surgeries or major procedures (including laser procedures or injections in or around the eye) as required by Illinois law and OMIC/AAO recommendations.

Eyeglasses: The updates are intended to increase compliance foremost by requiring certain prescribers to obtain a patient's signed confirmation of receipt of their prescription

allows prescribers, with a patient's verifiable affirmative consent, to provide the patient with a digital copy of a prescription in lieu of a paper copy; if the patient refuses the digital copy, the prescriber must provide a paper copy

explicitly specifies that, whether the patient consents to digital delivery or opts for a paper copy of their prescription, the prescription must be provided immediately after the examination is completed (not after the patient has been sold glasses, for instance). A patient must have their prescription before any offer to sell them glasses; clarifies that presentation of proof of insurance coverage shall be deemed to be payment for the purpose of determining when a prescription must be provided.

Information, Benefits, Risks, and AlternativesI understand that my provider will explain my eye condition, the recommended evaluation or treatment, and the material risks, benefits, and alternatives so I can make an informed decision. I understand that:

The purpose of exams, testing, and treatment is to diagnose and manage eye and vision problems and may help preserve or improve my vision.

No test or treatment is guaranteed to be successful or free of complications.

Possible risks from examinations, eye drops, and minor procedures include temporary blurred vision, light sensitivity, discomfort, allergic reactions, changes in eye pressure, corneal abrasion, infection, bleeding, inflammation, or, rarely, decreased or loss of vision.

Dilating drops can blur vision and increase light sensitivity for several hours; I may not be safe to drive or operate machinery until my vision clears, and it is my responsibility to use caution and arrange transportation if needed.

I understand that I may ask questions at any time and may refuse or delay any recommended test or treatment, and that my provider will explain, when appropriate, the likely consequences and risks of refusal.

Medications, Supplies, and Off-Label Use

I understand that my treatment may involve medications, diagnostic agents, and medical devices commonly used in eye care. In some situations, medications or devices may be used off label, in a manner not specifically described in FDA-approved labeling, when in my provider's judgment this is appropriate and consistent with accepted standards of care. I may ask about any medication, drop, or procedure before it is given. **Dilation** Summary: Dilation involves using eye drops to widen the pupil, allowing for a better view of the inside of your eye. This procedure may cause temporary blurred vision and light sensitivity. It is recommended to bring sunglasses and avoid driving immediately after your appointment

Minors, Legal Representatives, and Emergencies

I understand that in Illinois, consent is ordinarily given by an adult patient or by a parent/legal guardian or other authorized representative for a minor or an adult who lacks capacity, subject to specific statutory exceptions. I understand that in an emergency, when delay could seriously harm my health or vision and it is not feasible to obtain consent in time, my physician may provide treatment that is immediately necessary, consistent with Illinois law.

If I am signing as a parent, legal guardian, or other legally authorized representative, I confirm that I have authority under Illinois law to consent to treatment for this patient.

Photographs, Imaging, and Medical Records

I consent to taking photographs and diagnostic images (such as external photos, retinal photographs, OCT, angiography, and similar imaging) as part of my medical care. I understand that:

These images and test results will be part of my medical record and may be used to diagnose and monitor my condition and to communicate with other healthcare providers involved in my care.

De-identified images may be used for quality improvement, internal education, and professional teaching consistent with AAO/OMIC guidance; separate written authorization will be obtained if images that identify me are used for external education, publication, or marketing.

I authorize Northwest Eye Clinic to use and disclose my health information as permitted by federal and Illinois privacy laws and as further described in the clinic's Notice of Privacy Practices, which I acknowledge I have been offered or received separately.

Communication and Coordination of Care

I authorize Northwest Eye Clinic to share information about my diagnosis and treatment with my primary care physician, referring to providers, and other healthcare professionals involved in my care, as allowed by law. I understand that the clinic may contact me using the phone numbers, addresses, and communication methods I provide (including patient portal and, if I separately consent, text or email) for purposes such as appointment reminders, test results, and care instructions, consistent with privacy requirements. Spectacle Prescription Release: Your spectacle prescription will be provided to you electronically to your patient portal automatically and upon request. Please sign below to confirm knowledge of receipt of your prescription.

Financial Responsibility and Insurance

I understand I am financially responsible for all charges for services I receive, including copayments, deductibles, coinsurance, non-covered services, and any balance not paid by my insurance or health plan. CC Authorization: I authorize Northwest Eye Clinic, Ltd. to swipe and keep my credit card information on file for future transactions. I understand that my information will be stored securely and not used without my authorization.

I must provide accurate insurance information and notify the clinic about any changes.

Some services (for example, refraction, certain diagnostic tests, or elective procedures) may not be covered by my insurance or by Medicare/Medicare Advantage, and I may be asked to sign a separate notice (such as Advance Beneficiary Notice) before receiving such services.

9. Acknowledgment and Right to Withdraw

I acknowledge that:

This general consent remains in effect for my ongoing care at Northwest Eye Clinic until I revoke it in writing, except where a separate consent is required. I have had the opportunity to read this consent (or have it read to me), to ask questions about my eye condition and proposed care, and that my questions have been answered to my satisfaction. I understand that this written form documents our informed-consent discussion but does not replace my right to ask questions or receive additional information. I may withdraw this general consent for non-emergency care at any time by notifying Northwest Eye Clinic in writing, understanding that withdrawal may affect my ability to receive further evaluation or treatment at this practice.

By signing below, I indicate that I understand and voluntarily agree to the evaluation and treatment described above at Northwest Eye Clinic

** SIGNATURE REQUIRED **