



Choose Your Screening Option:

The doctor's recommendations for each screening option are listed below.

PLATINUM: \$57.00
Recommended for Patients 55+

- ✓ Eidon Retinal Image Screening
- ✓ Optical Coherence Tomography (OCT)
- ✓ Spectral Microscopy Screening
- ✓ Visual Field Testing

GOLD: \$42.00
Recommended for Diabetic Patients & Patients 40+

- ✓ Eidon Retinal Image Screening
- ✓ Optical Coherence Tomography (OCT)

SILVER: \$29.00
Recommended for ALL Patients

- ✓ Eidon Retinal Image Screening

DILATION
Patients who decline screening

- ✓ Dilated Exam
- ✓ Covered by insurance

*Blurry vision and light sensitivity may occur

Non-Dilated Exam:
I understand that most peripheral diseases of the retina **CANNOT** be detected with this method. This has a limited view and will **ONLY** detect large defects.

Option Selected: _____

- **Eidon Retinal Imaging:** This instrument allows the doctor to see 200 degrees out into the periphery of the retina, Dr. Merchant suggest this be done every year.
- **Optical Coherence Tomography (OCT):** A noninvasive imaging test that uses light waves to take cross-section pictures of your retina. The OCT allows the doctor to view the different layers of the retina as well as the choroid beneath. This test helps in detecting & treating of retinal eye diseases such as Glaucoma, Macular Degeneration, and Diabetic eye disease.
- **Spectral Microscopy Screening:** This instrument is used to detect any abnormalities in the cornea which is the front surface of the eye. Corneal dystrophies can lead to vision loss. Dry eye and ocular allergies can affect this corneal layer.
- **Visual Field Testing:** Analysis the visual field for abnormalities in the peripheral vision.
- **Dilation:** The doctor will insert eye drops that will cause your pupils to widen, which allows more light into your eye which allows him to have a better view of the back of your eye.

The enhanced screenings do provide valuable insight into the health of your eyes. They are considered optional because they are **NOT** covered by insurance.

Name: _____ Date: _____