PATIENT'S NAME:

DOB:

CONSENT TO TREAT MINORS

I _____ (parent/legal guardian) of _____(patient's name) consent to any medical and routine vision care determined by Within Sight Vision Center, Dr. Chase Hunter, and associates to be necessary for the welfare of my child in my absence. I will not be present during the appointment and, therefore, give my consent for my child to be seen by Within Sight Vision Center and Dr. Hunter, and associates. I also understand that I am responsible for payment of any services rendered during the visit.

Print_____ Sign _____ Date_____
(parent/legal guardian) (parent/legal guardian)

PLEASE COMPLETE THE FOLLOWING:

1. I give consent for this minor to receive a retinal photo** (out-of-pocket charge: $39)
   _____ YES _____ NO
2. I give consent for this minor to have a contact lens evaluation (out-of-pocket charge: $65-105)
   _____ YES _____ NO
3. I give consent for this minor to be dilated (no out-of-pocket charge)
   _____ YES _____ NO

**Digital retinal photography provides both the patient and the doctor with a digital photo of the back of the patient's eye and reduces the need for dilation if the pupils are large enough for clear, readable photos. This process can aid in the early detection of several disorders and eye diseases, such as

- brain tumors
- glaucoma
- diabetes
- macular degeneration
- retinal lesions

Insurance does not cover this
There is an additional $39.00 charge for the Digital Retinal Photography Testing