DAVID W. BANG, O.D.
KIMBERLY M. HUNT, O.D.

American Optometric Association

Diagnostic Testing

RF Photography, OCT and/or Topography

The digital retinal imaging system takes images of the retina (the back of the eye). The procedure assists the doctor in the early detection of many disorders, including keratoconus, cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other conditions.

These diagnostic procedures are necessary for a comprehensive exam. We will bill your **medical** insurance company for diagnostic procedure(s). **We will bill you for the co-pay/deduct, if there is any.**

YES____ I want to receive a comprehensive exam and diagnostic testing (if needed).

NO_____ I do not want a comprehensive exam. I decline diagnostic tests.

Signature (Parent if patient is a minor) Date

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**
   - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
   - Co-payments are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**
   I hereby authorize and direct payment of my medical benefits to David W. Bang, O.D. on my behalf for any services furnished to me by the providers.

   Name_____ Date of Birth _____

Signature (Parent if patient is a minor) Date