ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received and read a copy of Commonwealth Family Eye Care, PLC's Notice of Private Practices (HIPAA).

_____

Signature of patient (parent or guardian, if minor) Date

_____

Printed name of patient (parent or guardian, if minor) Date

VISUAL FIELD SCREENING

We would like to offer you a highly sophisticated computerized instrument that allows us to provide a more thorough visual field screening analysis of your vision. This instrument checks for areas of vision loss in both the central and peripheral fields of vision. Visual fields testing can assist in early detection of glaucoma, retinal problems, and neurological diseases including optic nerve disorders or even tumors located in certain areas of the brain.

An individual does not notice most visual field defects until the very late stages. Virtually all of the major causes of blindness in the United States can be detected by changes in the visual field.

We recommend that all of our patients receive this test as part of their comprehensive eye examination. The fee for this screening is **$25.00**. Please check the appropriate area stating your preference and sign below. If you have any questions, the doctor will be happy to discuss this screening in more detail.

[ ] I WANT the visual field screening

[ ] I DECLINE the visual field screening

[ ] I would like to discuss this procedure with the doctor

_____

Signature of patient (parent or guardian, if minor) Date

** This test is a screening. It is possible that an additional and more comprehensive visual field testing may be necessary based on the results of the screening. **