SUNY COLLEGE OF OPTOMETRY
UNIVERSITY EYE CENTER®

Required Forms Checklist for Parent/Legal Guardian for Minors Accompanied by Another Adult

- If a parent or legal guardian cannot accompany your minor child during their appointment at The University Eye Center, the parent or legal guardian **MUST** designate an adult to accompany your minor child.
- The attached forms **AND** government IDs **MUST BE 1) completed, 2) personally signed and 3) submitted to The University Eye Center at least 3 business days before the appointment date.**

1. COMPLETE REQUIRED FORMS AND COPY OF 2 GOVERNMENT/LEGAL PICTURE IDS:

1) Consent to Designate Adult to Make Medical Decisions for Minor
   - **a.** Read the Deferred Consent to Dilate Eye
   - **b.** Read the Patient Guide **at** https://sunyopt.cld.bz/Welcome-Brochure which includes the Notice of Privacy Practices, the Patient Bill of Rights and the UEC insurance and payment policies. Please initial on the Consent Form that you have read these notices.

2) Consent for Examination and Treatment

3) Copy of the legal ID with picture and address of the parent signing the documents

4) Copy of the legal ID with picture and address of the adult who will be accompanying the child

2. SEND PACKAGE TO YOUR CHILD'S NEXT APPOINTMENT LOCATION:

Location	Email	FAX	Telephone	BEST METHOD
Pediatrics	Pediatrics@sunyopt.edu	212-938-5796	212-938-4185	Safe and Secure Send Message and attach documents via **Patient Portal**
Primary Care	PrimaryCareFrontDesk@sunyopt.edu	212-938-4127	212-938-4130	
Advanced Care	Advancedcarefrontdesk@sunyopt.edu	212-938-4099	212-938-4090	
Contact Lens	8thfloorfrontdesk@sunyopt.edu	212-938-4135	212-938-4155	
Vision Rehabilitation	5thflstaff@sunyopt.edu	212-938-4065	212-938-4062	

- **Before the date of the appointment**, call your doctor's office to ensure that all documents are received and properly completed.
- If the forms are not received, completed in full, or the copies of ALL identification cards are not received we will need to rebook your child's appointment until the forms are completed and received.
- A consent form needs to be completed in advance of the appointment for every child and for each adult who may accompany the child.
- These forms are good for no more than one year and must be updated before the end of the period. It is the parent's responsibility to ensure that there are current consent forms on file at the doctor's office in advance of the appointment.

You can also find these documents on UECs' website at universityeyecenter.org or via your child's University Eye Center Patient Portal.

CONSENT TO DESIGNATE ADULT TO MAKE MEDICAL DECISIONS FOR MINOR

1. I _____, am the parent of the child identified below. I have the power to make medical decisions for my child, and **have completed and signed each part of the Consent for Examination and Treatment / Payment Authorization form**.
There are no court orders that limit that power or which prohibit me from designating another adult to make health decisions for my child.

Child Name: _____ Date of Birth: _____

2. By signing below, I hereby authorize the following adult _____ (**Designee**) to make health decisions for my child.

3. This authorization shall begin on _____ and shall be valid for one year, unless an earlier termination date is written below.

Earlier Termination Date (if any): _____
This authorization may be revoked at any time by one or both parents.

4. During the period of this Authorization, the **Parent(s)** can be reached at:

Parent 1 Name: _____ Parent 2 Name: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____

During the period of this Authorization, the **Designee** can be reached at:

Designee Name: _____
Designee Address: _____
Designee Cell Phone: _____

5. The person I designate on this form shall be entitled to make health care decisions for my child at the SUNY College of Optometry University Eye Clinic (UEC).

Deferred Consent to Dilate Eyes: By initialing here _____ I acknowledge that I **DO NOT CONSENT** to having my child's eyes dilated at this time. *I acknowledge that I have read the attached "Deferred Consent to Dilate the Eyes" statement which outlines the benefits of dilation and the risks of not performing dilation at this time.*

6. **Parent(s) Signatures**
(Signatures of both parents required if court order requires parents to agree on health decisions)

Parent 1 _____ Date _____

Parent 2 _____ Date _____
Copy of Parent and Designee's Government Issued ID should be attached to this form. *Electronic signatures are not acceptable*

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UNIVERSITY EYE CENTER

UNIVERSITY EYE CENTER
33 W 42nd Street
New York, NY 10036
(212) 938-4001
universityeyecenter.org

Name: DOB: PN:

Consent for Examination and Treatment

By signing below, I give my consent for University Eye Center ("UEC") to provide me with appropriate and medically necessary eye care services, including routine diagnostic and treatment procedures. To the extent that more complex and/or invasive treatment is required, I understand that the UEC will provide me with additional information so that I can provide informed consent for such procedures. I also understand that since the UEC is a teaching facility, residents and students may observe and/or assist in my care, under the direction of my treating clinician or other appropriate staff members.

I acknowledge that no guarantees have been made to me with respect to the results of any treatment or examination provided by the UEC.

I understand that photographs, video or other images (collectively "images") may be taken of me and used for medical purposes such as documenting or planning my care as well as for teaching or for publication in a scientific journal. We will obtain your authorization prior to any publication or disclosure of images which may identify you.

This consent has been fully explained to me and I certify that I understand its contents.

By: _____ Date: _____
Signature of Patient Legal Guardian

If legal guardian, indicate relationship: _____

Research OPT-Out

☐ I DO NOT wish to be contacted regarding potential research studies. **Patients Initials**_____

Advanced Directives

Do you have an advanced directive document that names someone to make healthcare decisions on your behalf? ☐ Yes ☐ No

Explain: _____

Acknowledgement of Receipt

The notices listed below are included in the Patient Guide made available during your appointment and are listed on The University Eye Center website at https://www.universityeyecenter.org/.Please let the front desk team know if you have any questions.

By Initialing below, I acknowledge that I have been provided with a copy of:

- The Notice of Privacy Practices which details how certain health information about me may be used and disclosed by the UEC of the State University of New York, College of Optometry and how I may obtain access to and control this information.
- Patient bill of right and grievance procedures; and
- UEC Insurance and payment policies. **Patients Initials**_____

Signature on File / Payment Authorization

I request that payment for all services rendered by this facility be made on my behalf to the University Eye Center (UEC). I authorize the UEC to release to the Centers for Medicare and Medicaid (CMS) and its agents or any other insurer any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that my signature will serve as a lifetime authorization for the release of medical information necessary to pay the claim. If another insurer is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

I also understand that:

- If my insurance company requires a referral/authorization which is not available at the time of service, I will be financially responsible for the entire charge for the services rendered.
- I am responsible for all charges not covered by my insurance benefits, including the refraction charge.
- I have been given a copy of the UEC's insurance and payment policies and agree to abide by these policies.

Signature: _____ **Date:**_____

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Patient Name:_____**PN:**_____

Deferred Consent to Dilate the Eyes

I have read and understand the purpose of dilation as explained below. I choose to decline a dilated exam at this time for myself or my dependent named below. I understand that there is a separate office visit fee if I choose to return for dilation at a later date. I understand that I am releasing the University Eye Center from any liability by not having the dilated exam. I have read, understand and agree to the terms described above.

Patient (Guardian) Signature:_____**Date:**_____

FACTS ABOUT DILATION

Dilation is an important part of a complete eye examination. Dilation will enlarge your pupil allowing a better view of your retina. By performing a thorough retinal health evaluation, we can check for problems that can occur without obvious patient symptoms due to the following:

- **Systemic Diseases**: Diabetes, High Blood Pressure, Cancer
- **Eye Diseases**: Cataracts, Glaucoma, Retinal Detachment, etc.

After a dilated exam you will normally experience light sensitivity and blurry vision (Dilation drops typically blur the near vision and may make reading difficult) for approximately 4-6 hours. Disposable sunglasses can be given to you at the completion of the examination and are recommended.

Most people will be able to drive once their eyes are dilated, as long as they have sunglasses (which we can provide if you didn't bring any). However, if you feel uncomfortable driving, or have never driven with your eyes dilated, it may be best to have a driver.