Oasis Eye Care
Optical & Med Spa

Dr. Trent McKinney,
Board Certified Ophthalmologist

- Cataract Surgery
- Dry Eye Lab

Dr. Alex Brocato,
Board Certified Optometrist

- Comprehensive Eye Exams
- Contact Lens Fitting

Patient Name: _____

Optical Coherence Tomography (OCT)

Optical coherence tomography (**OCT**) is a non-invasive tool that takes pictures of the back of your eye. It functions like an ultrasound, but uses light waves instead of sound to map the shape of your retina and optic nerve. The **OCT** aids the physician in diagnosing and managing various eye problems including: ***Macular degeneration, glaucoma, diabetes and other pathologies of the eye.***

This screening is **NOT** covered by your insurance and the cost is **$60**. Please indicate whether or not you would like to have this performed. If during the exam, your physician finds one or more of the above mention eye conditions, it may be covered by your insurance and the cost would be subject to your individual health care agreement.

- ☐ Yes, I wish to have the OCT Screening performed during my exam
- ☐ No, I do not wish to have the OCT Screening performed during my exam

_____ _____

Signature Date

Refraction Policy

A **REFRACTION** is an important part of a comprehensive eye exam and a glasses prescription cannot be dispensed without it. This test is performed by a skilled technician (or physician) using a phoropter. This test allows us to determine if a glasses prescription could be issued to achieve your best functional vision. Without a consistent refraction, it becomes increasingly difficult for a doctor to follow you for visual changes. However, the most important reason we require a yearly refraction is to protect your vision. Most silent diseases (***Glaucoma, Cataracts and Macular degeneration***) can be diagnosed and treated earlier if an annual refraction has been performed.

MEDICARE AND MOST MEDICAL INSURANCES DO NOT COVER THE COST OF A REFRACTION. THE OFFICE FEE FOR THIS IS $50 AND PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

I have read the above explanation about the purpose and need for a refraction and understand that I will be responsible for payment.

□ I wish to proceed with a Manifest Refraction as described above
□ I refuse the Manifest Refraction and accept the risk of missing a possible silent eye disease

_____ _____

Signature Date

1868 S. Tamiami Trail, Venice FL, 34293 **Phone**: 941.493.9393 **Fax:** 941.492.6650 **Email:** VeniceEyeDoctors.com