FREDERICKSBURG
EYE ASSOCIATES
755 S Washington St / Fredericksburg, Texas 78624

fbgeye.com
Phone **830.997.6535** FAX **830.997.9695**

Specializing in Surgery & Diseases of the Eye

Anne C. Pluenneke, MD **Charles D. Cohn, MD**

General Consent for Care and Treatment

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any unidentified condition(s) if needed.*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider or other health care assistant as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care or an examination at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

IMPORTANT NOTICE: IF YOU HAVE AN INSURANCE PLAN THAT YOU BELIEVE COVERS A ROUTINE eye examination with no diagnosis found, please be advised that if we find a disease or reportable diagnosis/disease/disorder during the course of the exam, those diagnosis/ disease/disorder codes will be placed on your insurance claim and reported as part of the billing process. We are not responsible if your plan does not cover the claim as a ROUTINE examination. Additionally, many plans DO NOT COVER refractive errors. (near-sighted, far- sighted, astigmatism).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Representative

Date