



RETINA VISION CONSULTANTS

GENERAL CONSENT FOR TREATMENT, IMAGING, AND RELATED SERVICES

Patient Name: _____ Date of Birth: _____

1. CONSENT FOR MEDICAL CARE AND TREATMENT

I voluntarily consent to evaluation, diagnosis, and treatment by the physicians and clinical staff of Retina Vision Consultants. This includes, but is not limited to:

- Eye examinations and diagnostic testing
- Retinal imaging and procedures
- Intravitreal injections, laser treatments, and surgical procedures
- Administration of medications and anesthetics

I understand that all medical procedures have potential risks, side effects, and complications, which my physician will explain as appropriate. I understand that no guarantees have been made regarding the outcome of my care.

I understand that this consent is ongoing and that I may withdraw my consent for future, non-emergent treatment at any time by notifying Retina Vision Consultants.

2. CONSENT FOR PHOTOGRAPHY, VIDEO, AND DIAGNOSTIC IMAGING

I consent to the taking of retinal and ophthalmic images, photographs, video recordings, and/or audio recordings during my care, including but not limited to:

- Clinical examinations
- Diagnostic imaging procedures (including OCT, Fundus Photography, Fluorescein Angiography, OCT-A, Ultrasound, and Visual Field testing)
- In-office procedures and surgeries

I understand that these images and recordings are an integral part of my medical care and may be used for:

- Documentation in my medical record
- Diagnosis, treatment planning, and continuity of care
- Quality improvement and staff training

I further understand that my images, recordings, and related data may be de-identified (with all personal identifiers removed) and may be used for education and research purposes only if I provide authorization below.

Optional Authorization for Teaching and Research:

I authorize de-identified use of my images, recordings, and data for teaching, education, and research

I do NOT authorize use beyond my medical care

My decision will not affect the care I receive.

3. CONSENT FOR GENETIC TESTING (IF APPLICABLE)

I understand that genetic testing may be recommended to evaluate inherited retinal conditions.

360 N. Bedford Drive, Suite 300
Beverly Hills, CA 90210
Tel: 310-269-8565
Fax: 310-269-8011
www.rvc360.com



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I understand that I will receive information about the purpose, benefits, limitations, and potential implications of genetic testing before making a decision, including possible implications for my family members.

I consent to genetic testing if deemed appropriate

I decline genetic testing

4. CONSENT FOR TISSUE / SAMPLE COLLECTION

I consent to the collection of biological samples (including blood, ocular fluid, or tissue) as part of my medical care. I understand that de-identified samples and associated clinical data may be used for research, education, and teaching purposes only if I provide consent below.

I consent to use of my de-identified samples and data for research, education, and teaching

I do NOT consent

My decision will not affect the care I receive.

5. PRIVACY

I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices and understand how my medical information may be used and disclosed in accordance with HIPAA regulations.

6. FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all services rendered in accordance with my insurance plan's terms and conditions, including deductibles, co-payments, co-insurance, and non-covered services.

7. ACKNOWLEDGMENT AND SIGNATURE

I certify that:

- I have read and understand this consent form

- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction

- I voluntarily agree to the above consents

Patient

Parent/Legal Guardian

Health Care Proxy/Power of Attorney (documentation attached)

Signature: _____ Print Name: _____

Date: _____

Staff/Witness Signature: _____

Print Name: _____

Date: _____

This general consent does not replace procedure-specific informed consent forms when required.