West Coast
MOBILE EYE CARE INC.

PERMISSION SLIP

Dear Resident/Family Member,

We are pleased to announce that **West Coast Mobile Eye Care, Inc**. is providing professional eye care services, on-site, to our residents. Benefits of these services include:

* Comprehensive and problem-oriented eye exams at facility
* Testing for high risk conditions such as glaucoma, cataracts, diabetes and hypertension
* Treatment for eye diseases, glaucoma, eye infections, dry eyes and other acute conditions
* Optometrists and equipment specially geared to the elderly
* Optical services, including fitting of eyeglasses, frames, lenses and repairs
* All eyeglasses engraved with the resident's name starting at $39 for a complete pair
* Coordination with Ophthalmologists for further care and follow-up after surgery and other procedures
* Medicare, Medicaid and HMO's assignment accepted
* Arrangements for exams and glasses available to private pay residents

It is our belief that optimal vision in the elderly population is critical for maximizing quality of daily life. We hope you share this view and look forward to participating in your loved one's eye health and vision care. Please fill out the form on the bottom of this sheet to notify the facility of your wishes. Thank you.

( ) YES, I would like eye care services on-site. ( ) NO, I would not like eye services.

RESIDENT NAME: _____

FACILITY NAME: _____

I authorize eye care services for the above mentioned resident for the following known eye problems/conditions:

__ Itching/Burning/Tearing
__Redness/Discharge
__Discomfort/Eyestrain
__Eye Pain/Headaches
__Pt. sees floaters/flashes
__Dryness/Film over Eyes
__Reading Difficulties
__Other_____

__Glaucoma
__Cataracts
__Macular Degeneration
__Double Vision
__Blurred Vision
__Decreased Vision
__Visual Field Loss
__Hx of Eye Surgery

Problems associated with:
__Walking Imbalance
__Pt. bumps into things
__ Recent Fall
__ Diabetes
__ Hypertension
__ MS/HIV/Other_____
__ Prednisone/Plaquenil/Other

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier to service described.

Resident/Designated Rep/Guardian Relationship Date

X_____ _____ _____

If there is no specific eye problem, but you wish to have these services, an eye exam can be done on a fee for service basis.

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