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Informed Consent for Patient Election of Refractive Surgery (LASIK/PRK/SMILE/ICL/RLE)

Post-Operative Care under Co-Managed Care Protocols

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Co-Managing Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This information is being given to you so that you can make an informed decision as to your care under our co-management protocol for refractive surgery patients.  You have the right to ask as many questions about the co-management as you would like before electing to be returned to your local co-managing doctor for post-operative care.

* I understand that if I elect co-managed care, both my co-managing doctor and my surgeon will be actively participating in my pre and/or post-operative care, with each doctor performing their special functions in a coordinated fashion.
* I understand my co-managing doctor will have a separate fee for their care not covered by payment collected by Specialty Eye Institute.
* I understand that if I elect to have refractive surgery, my surgeon will perform my surgery and that, as long as my operative eye(s) progresses normally and is deemed medically stable, I will then return to my co-managing doctor’s care.
* I understand that my surgeon’s office will send a report of my surgery and findings from my visits along with a planned protocol for my follow-up care to my co-managing doctor.  I also understand that if I should need to return to my surgeon for the remainder of my post-operative care, I may do so at any time.
* I understand that my co-managing doctor will see me once I’m deemed medically stable.  I understand all information from my post-operative visits with my co-managing doctor will be sent to my surgeon to become part of my permanent record. Should a problem arise, my co-managing doctor knows that they can send me back to my surgeon’s office.
* I understand that there will be ongoing communication between the doctors regarding my care.
* I understand that if I have any questions or concerns about my care, I am able to contact either my co-managing doctor or my surgeon.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Managing Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeon’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_