

## Pre and Post-Operative Case Management Consent Form

Dr. \_\_\_\_\_ is my primary care eye doctor. It is my desire to have my primary care eye doctor provide my pre and post-operative care for my laser vision correction procedure, which will be performed by Stanley Braverman, M.D.

I have discussed this pre and post-operative case management with my primary care eye doctor (prior to the pre-operative exam), and with Dr. Braverman (prior to my laser vision correction procedure). I understand that my primary care eye doctor is trained and qualified to lawfully provide pre and post-operative care of laser vision correction patients.

I understand that my primary care eye doctor will perform a pre-operative examination and, if I am a suitable candidate for a laser vision correction procedure, I will be referred to Dr. Braverman for further pre-surgical testing and the surgical procedure. I further understand that, notwithstanding the results of the preoperative examination, I will not undergo the surgical procedure unless Dr. Braverman is satisfied that I am a suitable candidate for the procedure. Both my primary eye care doctor and Dr. Braverman will explain the procedure to me, and Dr. Braverman will obtain my informed consent to the procedure.

I understand that Dr. Braverman will examine me immediately following the procedure, and will perform another postoperative examination the day following the procedure. If, at that time, Dr. Braverman is satisfied with my postoperative condition, he will direct me to my primary eye care doctor for additional postoperative case management.

I understand that, although my primary eye care doctor will be co-managing my postoperative care, Dr. Braverman, as the operating surgeon, is responsible for the management of my post surgical care. I also understand that my primary eye care doctor will keep Dr Braverman informed of the results of my post-operative visits, and will immediately notify Dr. Braverman should I experience any complications related to my laser vision correction procedure at any time after the surgery. In addition, Dr. Braverman may perform postoperative examinations whenever he believes it to be appropriate. Furthermore, I understand that I may elect to return to Dr. Braverman, rather than to my primary eye care doctor, for any of the follow-up visits.

I hereby authorize the surgical facility, Dr. Braverman, my primary eye care doctor, and any other health care professional involved in my surgical procedure or providing care to share any information relating to my health and vision that they deem relevant to providing me with continued quality care.

(OVER)

I understand that I will be charged a global fee collected by Dr. Braverman, which is intended to cover the preoperative examination, the surgical procedure, the charge by the laser facility for use of the surgical suite and equipment, and the post-operative follow-up care for a one year period. I understand that the portion of the global fee which is applicable to the pre and post-operative care is collected on behalf of and will be paid to my primary eye care doctor. I also understand that, if I do not undergo the surgical procedure for whatever the reason, I will still be responsible for the cost of the preoperative examination performed by Dr. Braverman and my primary eye care doctor. Those fees will be charged separately and will be applied to the global fee if surgery is done within 3 months. If an enhancement is deemed necessary by Dr. Braverman during the post-operative period of one year, it will be performed at no additional charge by Dr. Braverman, by my primary care eye doctor and by the laser facility. If an enhancement is done later than one year after the initial surgery there will be a charge for all services. There are no other warranties actual or implied.

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Surgeon's Name: Stanley D. Braverman M.D Date \_\_\_\_\_

Surgeon's Signature: \_\_\_\_\_

Co-managing Doctor's Name: \_\_\_\_\_

