

Sample Patient Informed Consent to Co-Management of Postoperative Care

This will confirm that my surgeon has informed me that I have the right to be seen by him/her during the entire postoperative period. I have also been informed that I have the option to have my postoperative care co-managed by Dr. [OPTOMETRIST], an optometrist, if my surgeon determines that my postoperative condition is stable, that it is not medically necessary for my surgeon to continue to provide me with postoperative care, and that it is clinically appropriate for Dr. [OPTOMETRIST] to provide me with the postoperative care. I also understand that I can change my mind and return to my surgeon's care.

I understand that, depending on the surgical procedure, all or only a portion of the fees may be covered by Medicare or my insurance company and that any remaining fees that are not covered will be my responsibility. In addition, it has been explained to me that it is not possible to precisely predict the specific postoperative care services that will be provided to me. However, I have been informed that, assuming my recovery proceeds without complications, I can expect to be charged approximately the following fees if my postoperative care is not co-managed by Dr. [OPTOMETRIST]:

Projected Services by Surgeon Alone	Fees typically covered by insurance or Medicare	Fees that are my responsibility

I have also been informed that, assuming my recovery proceeds without complications, I can expect to be charged approximately the following fees if my postoperative care is co-managed by Dr. [OPTOMETRIST]:

Projected Services by Surgeon	Fees typically covered by insurance or Medicare	Fees that are my responsibility

Projected Services by Optometrist	Fees typically covered by insurance or Medicare	Fees that are my responsibility

Finally, I have been informed that if my postoperative care is co-managed by Dr. [OPTOMETRIST], my surgeon and Dr. [OPTOMETRIST] each will provide me with an accurate and comprehensive itemized statement of the specific postoperative care services that they each provide along with the charge for each service. *[INCLUDE IF SURGERY COVERED IN WHOLE OR IN PART BY MEDICARE: I have been informed that I may receive additional statements and explanations of benefits from Medicare because the surgeon and the co-managing optometrist are both providing care.]*

I understand that my surgeon will provide my postoperative care until my surgeon determines that it is no longer medically necessary for him/her to do so. I have discussed my choice with Dr. [OPTOMETRIST] and have been advised that it is clinically appropriate for Dr. [OPTOMETRIST] to provide the necessary postoperative care to me. Dr. [OPTOMETRIST] will send my surgeon, [Dr. SURGEON], a report after each visit. I have been assured that Dr. [OPTOMETRIST] will contact my surgeon immediately if I experience any problems or complications that arise related to my surgery, and I will be referred back to my surgeon if it becomes necessary.

