

CO-MANAGING CONSENT FORM

Please bring this form to your pre-operative appointment.

Pre-operative:

I understand and consent to the fact that Dr. _____, a licensed ophthalmologist/optometrist, will provide my pre-operative care relating to my eye surgery for the following reason (circle all that apply): location / availability. The possible benefits or risk of this arrangement and the co-manager's qualifications have been discussed. I understand my payment obligations to Restore Vision Centers and/or co-managing physician and all other information that is presented to me about my pre- and post-operative care. I voluntarily consent to this co-management arrangement. I further authorize the surgeon, co-managing physician, and other healthcare personnel involved in performing the procedure and providing appropriate care to share relevant information with one another relating to my health, my vision, or this procedure.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME (Print): _____

CO-MANAGING SIGNATURE: _____ **DATE:** _____

CO-MANAGING NAME (Print): _____

Post-operative:

I understand and consent to the fact that Dr. _____, a licensed ophthalmologist/optometrist, will provide my post-operative care relating to my eye surgery, for the following reason (circle all that apply): location / availability. The possible benefits or risk of this arrangement and the co-manager's qualifications have been discussed. I understand my payment obligations to Restore Vision Centers and/or co-managing physician and all other information that is presented to me about my pre- and post-operative care. I voluntarily consent to this co-management arrangement. I further authorize the surgeon, co-managing physician, and other healthcare personnel involved in performing the procedure and providing appropriate care to share relevant information with one another relating to my health, my vision, or this procedure.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME (Print): _____

CO-MANAGING SIGNATURE: _____ **DATE:** _____

CO-MANAGING NAME (Print): _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

PHYSICIAN NAME (Print): _____