Patient Name:

IEC Acct #:

DOB:

CO-MANAGEMENT AGREEMENT FORM

Cataract Surgery

Dr. ________________________________, and/or their associate at Illinois Eye Center will be performing ophthalmologic surgery on me. It is my desire to have my own optometrist, Dr. __________________________, perform my postoperative follow-up care. I wish to be followed by my optometrist because:

Patient Initial	Optometrist Initial	
_______	__________	Surgeon's unavailability
_______	__________	Clinically appropriate and in patient's best interest
_______	__________	Travel, illness, leave, in a rural area, surgery performed in a designated physician shortage area.
_______	__________	Patient cannot travel
_______	__________	Patient Request

I understand that I will not see Dr. ______________________________until it is clinically appropriate as determined by my surgeon. I have been assured that my surgeon will be contacted immediately if I experience any complication related to my cataract surgery, and I will be referred back to my surgeon if it becomes necessary. I also understand that I have the right to receive treatment from the surgeon at all stages of care and my surgeon will determine what type of procedure I need/qualify for. Once that is determined, I may not be able to return to my doctor until after the post-op care is finished and this agreement would become void.

I have been informed that I may receive additional statements and explanations of benefits from Medicare or my Insurance Carrier, because two physicians are providing care. However, there is no additional cost to Medicare, my Insurance Carrier or me by virtue of this arrangement.

The risks, benefits, and logistics of this arrangement have been explained to me and I desire to proceed, if the performed procedures qualifies for co-management.

____ ________________________________

Patient Name: Please Print Date

____ ________________________________

Patient Signature Date of Birth

==
=

I have agreed to provide post-operative care for _____________________________ following cataract surgery. I look forward to assuming his/her care when the operating surgeon believes it is clinically appropriate. I will keep Illinois Eye Center advised of his/her progress and will contact his/her surgeon if the patient has complications which warrant the attention of a surgeon.

____ ________________________________

Optometrist's Signature Date

==

I acknowledge receipt of this fully completed and signed form.

IEC-333
2/24 AKJ

Patient Name:

IEC Acct #:

DOB:

______________________________ ______________

Surgeon’s Signature | Date

______________________________ ______________

Surgeon’s Signature, if applicable | Date