ILLINOIS eye CENTER
Your Vision Empowered℠

IEC Account #_____

CO-MANAGEMENT AGREEMENT FORM
Cataract Surgery

Dr. _____, 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.

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.

_____ _____
Patient Name: Please Print Date

_____ _____
Patient Signature Date of Birth

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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

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I acknowledge receipt of this fully completed and signed form.

_____ _____
Surgeon's Signature Date