KELLIS EYE & LASER CENTER
OPHTHALMOLOGY & OCULOPLASTIC SURGERY

REQUEST FOR KELLIS EYE CENTER TO CO-MANAGE CATARACT PATIENT

Optometrist to Return Completed Form to FAX: 440-285-8448 Attn: Dana
(Please send form to Kellis Eye Center to initiate the process of us calling patient to schedule consult)

Date: _____

Patient Name: _____ **DOB**: _____

Insurance: _____**Pt Phone:** _____

Procedure:

Cataract Extraction With Lens Implant: _____ Right Eye _____Left Eye

Surgeon:
_____ Augustine J. Kellis, M.D. _____ Gene Aidan Johnson, M.D. _____ Julieta Ryder, M.D.

I _____ *(patient)* voluntarily, knowingly and willingly desire to have Dr. _____ *(optometrist)*, my optometrist, perform follow-up care after my cataract surgery. I authorize Kellis Eye Center to release copies of my surgical records to my optometrist during my 90 day postoperative period.

I understand that I will not see my optometrist until it is clinically appropriate. I have discussed my choice with my optometrist and have been advised that he/she is competent to perform the necessary follow-up services for me. I have been assured that Kellis Eye Center will be contacted immediately if I experience any complication related to my cataract surgery, and I will be referred back to Kellis Eye Center if it becomes necessary.

I have been informed that I may receive additional statements and explanations of benefits from Medicare/my insurance company, because two physicians are providing care. However, there is no additional cost to 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's Signature Date

I have agreed to provide postoperative care for the above-named patient following cataract surgery. I look forward to assuming his/her care when you believe it is clinically appropriate. I will keep you advised of his/her progress and will contact you if the patient has complications which warrant your attention.

_____ _____
Optometrist's Signature Date

Phone Number:_____ Fax Number:_____

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I acknowledge receipt of this fully completed and signed form.

_____ _____
Surgeon's Signature Date