independent VISION GROUP

LASER CORRECTION POST-OPERATIVE CARE CONSENT

The health and care of our patients is the primary concern of Dr. Harvey, Independent Vision Group, Ltd (IVG), and Dr. _____ at _____.

You have elected to undergo a surgical procedure to improve or maintain your vision. As a patient, you have the right to decide if you wish to participate in co-management of your care. That means while your surgery will be performed by Dr. Harvey, for convenience and familiarity you may wish to elect to receive your post-operative care from your optometrist/ophthalmologist. This option is only available to patients when it is clinically appropriate.

In order to provide you with appropriate care, during the course of your surgical care and post-operative recovery period, personal health information will be exchanged between IVG, the surgical facility, and your optometrist/ophthalmologist.

☐ I **AGREE** to the above stated post-operative arrangement. I am electing to have my optometrist/ophthalmologist provide my post-operative care. I understand transfer of care and the risks and benefits associated with this process. I have had all of my questions answered to my satisfaction and will call IVG if other questions arise.

In signing this agreement, it is mutually understood that my optometrist/ophthalmologist will provide post-operative care in his/her office but, at any time during my recovery, Dr. Harvey and IVG will be available to discuss my care by phone at 715.449.8400 or evaluate me at one of IVG's locations.

In signing this agreement, I agree to the release of my personal health information between my optometrist/ophthalmologist, IVG, and the surgical facility. I authorize all doctors and other health care personnel involved in performing this procedure and providing care to share with one another information relating to my health, my vision and this procedure which is deemed relevant, in order to provide me with appropriate care and process all insurance claims.

OR

☐ I **DO NOT AGREE** to the above stated post-operative arrangement. I am electing to have Dr. Harvey provide my post-operative care. In signing this agreement, it is mutually understood that Dr. Harvey will provide post-operative care at one of IVG's locations.

Patient Name _____ Date of Birth _____

Signature _____ Date _____ Witness _____