MARION EYE CENTERS - CONSENT FOR PROCEDURE

PATIENT:_____CHART:_____DATE:_____

I hereby authorize Dr. _____ and whomever he may designate as his assistants to perform upon myself:

LASER RETINOPEXY TO THE RIGHT EYE/LEFT EYE FOR ONE YEAR

If any unforeseen condition arises in the course of the operation calling on their judgment for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.

I understand and accept the nature and purpose of the procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications including decrease in vision, blindness, enucleation, chronic pain, permanent disability, and death. This has been fully explained to me and I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

I certify that I have read and fully understand the above Consent, and that all blanks or statements requiring insertion of completion were filled in before I affixed my signature. I have been encouraged to discuss the risks and complications with my family before proceeding with the procedure.

I understand and accept that other qualified, competent licensed Marion Eye Center ophthalmologists and/or optometrists other than the operating surgeon may provide my post-operative care. I understand I may choose to return to my surgeon at any time for post-operative care.

SIGNED:_____
(PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PROCEDURE)

WITNESS:_____

I request that payment of authorized Medicare benefits/insurance benefits be made either to me or on my behalf to the Marion Eye Center for any services furnished. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits payable for related services.

INSURANCE:_____PREAUTHORIZATION:_____