PLACE LETTERHEAD HERE AND REMOVE NOTE.
CHANGE FONT SIZE FOR LARGE PRINT

NOTE: THIS FORM IS INTENDED AS A SAMPLE FORM. IT CONTAINS THE INFORMATION OMIC RECOMMENDS YOU AS THE SURGEON PERSONALLY DISCUSS WITH THE PATIENT. PLEASE REVIEW IT AND MODIFY TO FIT YOUR ACTUAL PRACTICE. GIVE THE PATIENT A COPY AND SEND THIS FORM TO THE HOSPITAL OR SURGERY CENTER AS VERIFICATION THAT YOU HAVE OBTAINED INFORMED CONSENT.
Version 11/01/06

MODEL FORM

This form assumes that if you have to do any specific procedure, you will have a discussion with the patient regarding the risks, benefits and alternatives related to that particular surgery or treatment e.g. an enhancement. This “informed consent” is simply setting forth an understanding between the patient and the practice on certain issues of overall care.

ASSUMPTION OF LASIK POST-OP CARE

I understand (practice/physician name) will treat the current condition of my eye/eyes secondary to previous refractive procedure performed by a surgeon at a facility which was not associated with the (practice/physician name). (practice/physician name) informed me of my option to return to the surgeon who performed the procedure but it is my choice to be treated at (practice/physician name). My reason(s) for choosing to be treated at (practice/physician name) instead of returning to the refractive surgeon is(are) ____
____
____

(In patient’s own handwriting to show that she had her own reasons to stay with you.)

I understand that the (practice/physician name) in no way guaranteeing any cure of my current condition which includes ____
____
____

(In patient’s own handwriting to document in her own words the complaints/reasons for being at your practice. If simple, uncomplicated post-op follow-up then let her state that).

I also understand that the (practice/physician name) is not accepting any liability or responsibility for the loss of vision or diminished quality of vision associated with the prior surgery.

I have had possible associated risks and consequences of treatment versus no treatment explained to me. As with all types of treatment, I understand there is the possibility of complications and an unsuccessful resolution of the current condition.

I understand that I will be charged at normal (practice/physician name) fees for service. Payment for those services will be made on the day of the exam or subsequent treatment.

(practice/physician name) has answered all my questions about my proposed course of treatment at this time.

Patient Signature Date

Witness Signature Date