Co-management Consent Form

Patient Name: _____ Date of Birth: _____

Dear _____, M.D.

I voluntarily, knowingly, and willingly request that _____, O.D., my optometrist, provide follow-up care after my cataract surgery once my surgeon has determined that such care is clinically appropriate.

I understand that I may choose my optometrist for postoperative care for personal reasons, including but not limited to comfort, convenience, familiarity, travel distance, and office-hour availability.

I acknowledge that my optometrist will contact my surgeon immediately if I experience any complications related to my cataract surgery and that I will be referred back to my surgeon if necessary.

Medicare Part B Beneficiaries Only:
I understand that I may receive additional statements and explanations of benefits from Medicare because two providers are involved in my care. However, there will be no additional cost to Medicare or to me because of this arrangement.

_____ _____
Patient Signature Date:

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I agree to provide postoperative care following the patient's cataract surgery.

_____ _____
Optometrist Signature Date: