eye CARE center
of northern colorado, pc

CONSENT FOR CO-MANAGEMENT AFTER REFRACTIVE SURGERY

Patient Name: _____ Date of Birth: _____

Patient Confirmation

Aimee Verner, M.D. will be performing LASIK/PRK/ICL on me on _____

Plus One Day post-op exam on: _____.

Due to travel, convenience or other circumstances, it is my desire to have my own ophthalmologist/ optometrist, Dr. _____, perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon, Dr. Verner.

Dr. Verner has informed me that an optometrist may lawfully provide postoperative care under applicable state law. I understand that my ophthalmologist/optometrist will contact Dr. Verner immediately if I experience any complications related to my eye surgery. *I understand that I may also contact Dr. Verner at any time after the surgery.*

Patient Signature: _____Date:_____

Witness Signature: :_____Date:_____

Ophthalmologist/Optometrist Confirmation

I have agreed to provide follow-up care for _____. I will see the patient after surgery when Dr. Verner notifies me that she/he is releasing the patient to my care. I agree to notify Dr. Verner immediately should complications arise and to provide written progress reports during my portion of the postoperative period.

Co-Managing Doctor Signature: _____ Date: _____