Donelson Eye Associates

Dear ______________________________,

We appreciate your selection of our office for your complete eye care.
First visits usually take approximately 2 to 2 1/2 hours. Dilation of your eyes will probably be required for the examination. Since the effect of this procedure can take 1 to 2 hours to wear off, it is best that you not plan on driving immediately after the appointment and that you arrange for other means of transportation to return home.

We ask that you kindly cooperate with the following requests:

- Complete the enclosed **Patient Registration Form, the Medical History Questionnaire** and the **Pharmacy Information Sheet.**
- **Bring a list of any medications and eye drops** that you currently use as well as your eyeglasses.

TO HELP PROTECT YOUR IDENTITY and as DICTATED BY FEDERAL LAW we must ask you to provide certain information to our office:

- **Bring current copies of all insurance cards, including Medicare and Medicaid.**
- **Bring your driver's license or other government issued ID. If you do not have a government issued ID bring two other forms of identification (e.g., a Social Security card and a utility bill) at least one showing your current address.**

FINANCIAL INFORMATION

- **Self Pay**
  Payment is expected at the time of service for all procedures unless prior arrangements are made. Copies of our fee bill are provided for your convenience in filing claims to your insurance carrier.

- **Medicare**
  We will file all claims to Medicare with a valid signature on file. **Routine eye exams and "refractions" are not covered by Medicare** and payment is requested at the time of service. **(A "refraction" is the test done to determine a prescription for glasses.)**

- **Health Plans**
  All claims will be filed for you to your insurance carrier. Please check your insurance handbook or check with your insurance company before scheduling an appointment to be sure you will be seeing a participating provider. If you are in need of a referral from your primary care physician's office, please be sure to have that sent prior to your visit. You will be responsible for any charges not covered due to lack of referral. **We are not contracted with any "Vision Plans".**

Patient Signature

______________________________***Date***______________________________

Feel free to contact our office if you have any billing or insurance questions. Our staff will be happy to assist you. P (864-987-0034) f (864-987-0036)

Donelson Eye Associates

Congratulations on your decision to take the next step toward improving the quality of your vision.

Your evaluation is scheduled for ________________________at ______________.

During this appointment, the doctor will give you a detailed dilated eye exam, confirm your eligibility for surgery, and help you decide on the best corrective option.

While you'll most likely be able to drive yourself home after having your eyes dilated, you may be more comfortable having a friend or family member drive you home after your exam.

YOU WILL "NOT" BE HAVING SURGERY ON THE DAY OF YOUR EVALUATION.

CONTACT LENS WEARERS - PLEASE NOTE:

Soft Contact Lens: Please do not wear your soft contact lens for **2 weeks** prior to your evaluation.

Gas Permeable Lens: Please do not wear your gas permeable lens for **3 weeks** prior to your evaluation. Accurate measurements of your eyes must be taken during this evaluation. These measurements *will not* be accurate if you have not been out of your contacts.

If it is determined that your contact lens have *not* been out for the time period stated above your appointment will have to be rescheduled.

David M. Donelson M.D.
1 Halton Green Way, Greenville, SC 29607 ♦ 864-987-0034

Donelson Eye Associates

Name: ____ Date: ______________________

Date of Birth: ______________ Sex: _________ Social Security #: ________________________

Mailing Address: ________________ ___Zip code__________ **Email:** ____________________

Phone: (Home)________________(Cell)________________(Work)________________

Occupation: ____________________________ If retired, previous employer: ______________

Medical Doctor: ________________Address: ______________________________________

Date Last Seen: ________________Next Appointment: ________________________________

Who referred you to our office? ____

Race/Ethnicity: White * Black or African American * American Indian or Alaska Native * Asian

Native Hawaiian or Other Pacific Islander * Hispanic/Latino

- **I understand that I will be responsible for any charges incurred by not providing the most current and correct insurance information to Donelson Eye Associates. I also understand that it is my responsibility to find out if my insurance carrier is contracted with Donelson Eye Associates.**
- **We are not contracted with any Vision Plans.**

Acknowledgement: I acknowledge that I have received and read the Notice of Privacy Practices. ___ Yes ___ No

Patient Signature: ____________________________________ **Date:** ________________

** * CONTACT LENSES * **

DO YOU CURRENTLY WEAR CONTACTS? YES_______ NO_______

ARE YOUR CONTACTS: SOFT_______ GAS PERM_______

PLEASE INDICATE THE DOCTOR CURRENTLY FOLLOWING YOU FOR CONTACTS:____________________.

** * GLASSES * **

*** Donelson Eye Associates charges a* ***$50.00 refraction fee*** *for the testing necessary to determine a prescription for glasses.* ***Also if you need cataract surgery, a refraction is needed and you will be responsible for payment for this test.*** *Most insurance companies, including Medicare, DO NOT cover refractions; however, a glasses prescription cannot be given without this test.*

______ YES, I NEED A GLASSES PRESCRIPTION. ______NO, I DO NOT NEED A GLASSES PRESCRIPTION.

My Pharmacy Information

Pharmacy Name: ______________________________ **Phone:** ____________________

Pharmacy Address: ____

Medical History Questionnaire

History of Present Illness:

What is the Main Problem that brings you here:______________________________________

In which eye: __________ For how long? ____

Have you noticed a change in your vision? ____

Do you have trouble:			
	Reading small print?	Yes__	No__
	Watching TV?	Yes__	No__
	Seeing to go up and down steps?	Yes__	No__
	Driving at night?	Yes__	No__
	Seeing road signs?	Yes__	No__

Last *EYE* exam:_________________________ Last *MEDICAL* exam: __________________________

Are you experiencing any of the following?

Distorted Vision__	**Loss of Side Vision__**	**Double Vision__**
Loss of Vision__	**Dryness/Dry Eyes__**	**Mucous Discharge__**
Excess Tearing/Watering__	**Redness__**	**Eye Pain/Soreness__**
Sandy or Gritty Feeling__	**Blurred Vision__**	**Glare/Light Sensitivity__**
Burning__	**Itching__**	**Tired Eyes__**
Flashes/Floaters in Vision__	**Foreign Body Sensation__**	

Ocular History:

Did any previous eye disorder result in vision loss? No_____ Yes_____

If yes, please describe:____

Have you had any eye diseases, surgery or injury? No_____ Yes_____

If yes, please describe:____

Do you wear glasses or contacts: No_____ Yes_____

If yes, how old is your prescription?____

Any history of Amblyopia or "Lazy Eye"? No_____ Yes_____

Past History:

Have you had any serious medical problems? No_____ Yes_____

If yes, please describe:____

____

Do you take aspirin or a blood thinner on a regular basis? No_____ Yes_____

Do you now or have you ever taken **Flomax (Tamsulosin), Avodart, Requip (Ropinirole) or Mirapex?** No or Yes

Medical History Questionnaire (page 2)

Please list any surgeries you have had:

____

____

Medications:

Please list all medications including eye drops which you are currently taking:

DRUG	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		

*** Have you ever had a pneumonia vaccination? No___ Yes___**

Allergies:

Do you have allergies to medication? **NO___ YES___** (If yes, please list below)

Medication	Reaction
1.	
2.	

Do you have reaction problems with local or general anesthesia? **NO___ YES___**

If yes, please describe the type of reaction:______________________________

Any other allergic reactions? **NO___ YES___**

If yes, please explain:______________________________

Social History:

Do you: Drink Alcohol___ Chew Tobacco___ Use Illegal Drugs___ Live Alone___ Exercise___

Do you currently smoke: Yes__ No__ If yes, how much? ______________________________

Have you *ever* smoked? Yes__ No__

Are you currently pregnant / nursing? Yes__ No__

Family History:

Are there any significant **eye diseases** or **other diseases** which run in **your family?** NO___ YES___

If yes, please list diseases: ____________________, ____________________, ____________________

Medical Questionnaire (page 3)

Review of Symptoms

Please check any symptom or problem that is **Chronic or Persistent.** Circle NONE if nothing in the category applies.

Constitutional: NONE

____Fever

____Weight Loss

____ Night Sweats

Ear, Nose, Mouth, Throat: NONE

____Hearing Loss

____Pain/Discharge

____Dizziness/Fainting

____Nose Bleeds

____Ringing in Ears

____Sinus Pain

Cardiovascular: NONE

____Chest Pain

____Irregular Heart Beat

____Shortness of Breath on Exertion

____Swelling of Feet

____High Blood Pressure

____Heart Attack/Disease

____Elevated Cholesterol or Triglycerides

Respiratory: NONE

____Shortness of Breath ____Sleep Apnea

____Asthma/Emphysema ____Cough

____Tuberculosis (TB)

____Other (Please describe):

Gastrointestinal: NONE

____Change in Bowel Habits ____Ulcers

____Diarrhea ____Constipation

____Stomach Pain ____ Acid Reflux

____Other (Please describe):

Endocrine: NONE

____Thyroid Disease

____Diabetes

Cancer: NONE

Please describe:

Musculoskeletal: NONE

____Pain/Swelling ____Weakness

____Lupus ____Fibromyalgia

____Arthritis, what Type ____________________

Skin/Breast: NONE

____Masses ____Rosacea

____Tumors ____Skin Cancer or Skin Cancer History

____Rash

____Other (Please describe):

Neurologic: NONE

____Numbness/Tingling

____Seizures/Epilepsy

____Weakness in Arm/Leg

____Lyme Disease

____Alzheimer's Disease

____Parkinson's Disease

____Migraines

____Stroke

Mood Disorders: NONE

____Anxious/Nervous ____Bi-Polar

____Depression

____Other (Please describe):

Genitourinary: NONE

____Kidney Trouble ___Prostate Disease

____Urinary Problem ___Venereal Disease

Hematologic: NONE

____Bleed /Bruise Easily

____Anemia

____Prior Blood Transfusion

____Sickle Cell Disease

____HIV+/AIDS and/or Exposure

____Hepatitis: B or C

Diabetics:

How long have you had diabetes?____________________

How often do you see your diabetic doctor?______________

How often do you test your blood sugar?______________

What was your blood sugar when last tested?__________

Your last Hemoglobin A1C?____________________

Visual Needs Questionnaire

Name ____

Date ____

1. How important is reducing or eliminating your need for glasses (after Lasik or cataract surgery)?

   ( ) extremely ( ) very ( ) somewhat ( ) not at all

2. How many hours per week do you spend driving after dark?

   ( ) less than 1 hour ( ) 3 hours ( ) more than 5 hours

3. How many hours per week do you spend reading or on the computer? (circle whether more time on computer or reading)

   ( ) less than 1 hour ( ) 3-5 hours ( ) more than 10 hours

4. What is your occupation and/or favorite past time?____

Eye Drop Prescriptions for Cataract Surgery

You are here today for an exam to determine if you need cataract surgery. If you need cataract surgery and elect to have Dr. Donelson perform your surgery our Staff is committed to assist you throughout the entire process.

Eye drops will be prescribed for cataract surgery. These eye drops are extremely important and must be used as directed to keep your eye healthy and to aid in the healing process.

These eye drops are usually covered by your insurance but are often still quite expensive, regardless of the brand. The eye drops prescribed by Dr. Donelson are made by Bausch & Lomb. Bausch & Lomb has a contract with **Walgreens Pharmacy** that will allow these eye drops to be purchased at a lesser cost than your regular pharmacy may be able to provide. It is our hope that the relationship between **Walgreens Pharmacy** and Bausch & Lomb will prove to be a more cost effective option for our patients when purchasing eye drops for surgery.

Please choose the **Walgreens Pharmacy** that you prefer to use from the attached list. Your prescriptions will be electronically transmitted to the Walgreens of your choice.

Patient Name: ____

PLEASE CIRCLE YOUR WALGREENS LOCATION

Greenville:

- Walgreens, 2008 Laurens Road, Greenville, SC 29607
- Walgreens, East North Street, Greenville, SC 29607
- Walgreens, 2018 Augusta Street, Greenville, SC 29605
- Walgreens, 6057 White Horse Road, Greenville, SC 29611
- Walgreens, 902 Pelham Road, Greenville, SC 29615
- Walgreens, 2700 Wade Hampton Blvd., Greenville, SC 29615
- Walgreens, The Parkway, Greenville, SC 29615
- Walgreens, 1801 Poinsett Hwy, Greenville, SC 29609

Simpsonville:

- Walgreens, 618 Fairview Road, Simpsonville, SC 29680
- Walgreens, 2586 Woodruff Road, Simpsonville, SC 29681

Laurens:

- Walgreens, 814 E. Main Street, Laurens, SC 29360

Mauldin:

- Walgreens, 104 Butler Road, Mauldin, SC 29662

Easley:

- Walgreens, 5312 Calhoun Memorial Hwy, Easley, SC 29640

Anderson:

- Walgreens, 2811 N. Main Street, Anderson, SC 29621
- Walgreens, 1412 E. Greenville Street, Anderson, SC 29621
- Walgreens, 2539 W. Whitner Street, Anderson, SC 29624
- Walgreens, 108 Highway 28 Bypass, Anderson, SC 29624

Powdersville:

- Walgreens, 3501 Highway 153, Greenville, SC 29611

Seneca:

- Walgreens, 1601 Sandifer Blvd., Seneca, SC 29678

Pickens:

- Walgreens, 101 Hampton Avenue, Pickens, SC 29671

Travelers Rest:

- Walgreens, 100 Little Texas Road, Travelers Rest, SC 29690

Greer:

- Walgreens, 1232 W. Wade Hampton Blvd., Greer, SC 29650
- Walgreens, 101 W. Wade Hampton Blvd., Greer, SC 29650 (near Hwy 14)

Spartanburg / Boiling Springs / Duncan:

- Walgreens, 2410 Reidville Road, Spartanburg, SC 29301
- Walgreens, 3681 Boiling Springs Road, Boiling Springs, SC 29316
- Walgreens, 2196 E. Main Street, Duncan, SC 29334

Greenwood:

- Walgreens, 1014 Montague Avenue, Greenwood, SC 29649

Other location not listed above: ____

PATIENT COMMUNICATION FORM

A. **Family and Friends**. It is the office policy of **Donelson Eye Associates** not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ______________________________ ______ yes ______ no

Son/Daughter: ______________________________ ______ yes ______ no

Parent: ______________________________ ______ yes ______ no

Other: ______________________________ ______ yes ______ no

B. **Alternative Communications**. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:______________________________

____

C. **In Case of Emergency Please Contact:**

Name: ______________________________

Phone #: ______________________________

PRINTED NAME______________________________

Patient/Parent/Guardian **Signature:**______________________________

Date: ______________________________

- -

FOR OFFICE USE
Changes to above authorized by patient over phone:

Change Initials	Date	Staff
______________________________	______	______
______________________________	______	______

Donelson Eye Associates, P.A. is required by law to maintain the privacy of Protected Health Information ("PHI"), to provide individuals with notice of our legal duties and privacy practices with regard to PHI, and to notify affected individuals following a breach of unsecured PHI. PHI is information that may identify you and that relates to your past, present, and future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

Donelson Eye Associates, P.A. is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in the Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request we will provide any revised Notice to you.

Your Health Information Rights

You have the following rights with respect to PHI about you:

Retain a paper copy of the Notice upon request. You may request a copy of the notice at any time. To obtain a paper copy, contact Donelson Eye Associates staff.

Request restrictions on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of PHI by sending a written request to Donelson Eye Associates Manager. We are not required to agree to those restrictions. However, we will agree to a request to restrict disclosure of PHI to your health plan if the disclosure is for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you have paid Donelson Eye Associates in full.

Inspect and obtain a copy of PHI. You have the right to access and copy PHI about you contained in a designated record set for as long as Donelson Eye maintains PHI. The designated record set usually will include prescription and billing records. To inspect or copy PHI about you, you must send a written request to your Donelson Eye Associates staff.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to the Donelson Eye Associates Manager. You must include a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you after April 14, 2003 for most purposes other than treatment, payment or health care operations. The accounting will exclude certain disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care and disclosure for notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to Donelson Eye Associates Manager. Your request must specify the time period, but may not be longer than six years.

Request communications of PHI by alternative means or at alternative locations. For instance you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of PHI about you, you must submit a request in writing to the Donelson Eye Associates Manager. Your request must state how or where you would like to be contacted. We will accommodate all reasonable requests.

Examples of how we may use and disclose PHI:

The following are descriptions and examples of ways we use and disclose PHI:

We will use PHI for treatment. Your medical information may be used to provide you with medical treatment and services. This medical information may be used by and disclosed to physicians, nurses, technicians, and others who are involved in your medical care. For Example: Information obtained by the pharmacist will be used to dispense prescription medications to you. We will document in your record information related to the medications dispensed to you and services provided to you.

We will use PHI for payment. Your medical information may be used and disclosed so that the Practice can bill and receive payment from you, your insurance company, and/or another third party for the treatment and services you received. For Example: We will contact your insurer to determine whether it will pay for your medical care and the amount of your co-payment. We will bill you or a third party for the cost of your visit and the amount of your co-payment. The information on or accompanying the bill may include information that identifies you, as well as the medical care you receive.

Communications with individuals involved in your care or payment for your care. After we give you the opportunity to agree or to object to the disclosure of your medical information, health care professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any person you identify, PHI relevant to that person's involvement in your case or payment related to your case.

Food and Drug Administration (FDA): We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to citable product recalls, repairs or replacement.

Workers Compensation: We may disclose PHI about you as authorized by and as necessary to comply with laws relating to workers compensation or similar programs established by law.

Public Health: As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.

Health oversight activities: We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations as necessary for our licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and administrative proceeding: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

Research: We may disclose PHI about you to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Organ or tissue procurement organizations: Consistent with applicable law, we may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Notification: We may use or disclose PHI about you to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and your general condition.

Correctional Institution: If you become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health.

To avert a serious threat to health or safety: We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety.

Military and veterans: If you are member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.

National security and intelligence activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other nation security activities authorized by law.

Victims of abuse, neglect, or domestic violence: We may disclose PHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that is necessary and will not be used against you.

Other Uses and Disclosures of PHI

Psychotherapy Notes. Will we obtain your authorization for use or disclosure of psychotherapy notes unless carrying out the following: (1) use by originator of the psycho therapy notes for treatment; (2) use or disclosure of the psychotherapy notes for training programs; (3) use or disclosure of the psychotherapy notes to defend ourselves in a legal action brought by you; or (4) use or disclosure of the psychotherapy notes to the U.S. Department of health and Human Services to determine our compliance with the regulations governing PHI.

Marketing. We will obtain your authorization before using your PHI for marketing purposes except when the marketing takes the form of: (1) a face-to-face communication made by us to an individual; or (2) a promotional gift of nominal value.

Sale of protected health information. We will obtain your authorization prior to the sale of your PHI.

Donelson Eye Associates will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except that we have already taken action in reliance on the authorization.

As Required by Law. Donelson Eye Associates will disclose PHI as required by federal, state, or local law.
For more information or to report a problem: If you believe your privacy rights have been violated, you may file a complaint with the Donelson Eye Associates Manager, one of the physicians, or with the Secretary of Health and Human Services. There will not be retaliation for filing a complaint. To file a complaint, call the office manager of Donelson Eye Associates at (864) 987-0034. To ensure proper follow-up, complaints must also be submitted in writing.

David M. Donelson M.D.
1 Halton Green Way, Greenville, SC 29607
864-987-0034/Donelson Eye Associates Manager: Hope Garrett

DONELSON EYE ASSOCIATES

INFORMED CONSENT FOR CATARACT CORRECTION, ASTIGMATISM REDUCTION, PRESBYOPIA REDUCTION AND / OR IMPLANTATION OF AN INTRAOCULAR LENS.

CONDITION(S):

Cataract: a clouding of the natural lens of the eye than can cause blurred vision.

Presbyopia: a condition where the focusing lens of the eye loses its ability to focus at near. This results in difficulty seeing objects up close without the help of reading glasses. I understand that when I have my natural lens (cataract) removed, I will likely need to wear reading glasses unless I opt for a multifocal lens implant or monovision correction.

Astigmatism: a condition in which the surface of the eye is shaped like a football (oval) rather than a basketball (round). Due to the abnormal shape of the eye (football vs basketball), people with astigmatism often have vision that is out of focus, blurry or even doubled. Astigmatism typically causes blurred vision at all distances, near and far. I understand that when I have my natural lens (cataract) removed, I will likely need to wear glasses for both distance and near vision unless I opt for an Astigmatism Correcting lens or other astigmatism reducing procedure.

PROCEDURE(S):

Cataract Surgery

I understand that cataract surgery may improve my vision and that when my cataract surgery is performed, an artificial lens implant (IOL) will be implanted to replace the natural lens of my eye that has developed a cataract. I also understand that rarely, certain conditions may arise during surgery or were present before surgery, that may prevent the surgeon from implanting the type of IOL initially planned for, or even more rarely, any IOL at all. If this is the case, I understand that an IOL can often be implanted with a second procedure at a later time. I understand that there are many options for vision correction with cataract surgery and that I can choose to customize my cataract surgery to achieve the best possible visual outcomes.

Custom IOL Implant Options

Single Focus or Monofocal lens with Glasses: You can choose to have a monofocal (single focus) IOL implanted for distance vision and wear separate glasses for reading vision, or have the IOL implanted for near vision and wear separate glasses for distance vision. The likelihood of needing glasses after surgery with a monofocal IOL is high. This lens is a covered expense by your insurance company.

Monovision: Your surgeon could implant IOLs with two different powers, one for near vision in one eye, and one for distance vision in the opposite eye. This combination of a distance eye and a reading eye is called Monovision, and would allow you to read and see in the distance for most things without the need for glasses. It has been employed quite successfully in many contact lens and refractive surgery patients. Your surgeon will discuss and demonstrate this option, as everyone is not a good candidate. These are single focus or monofocal lenses and are covered by your insurance company.

Multifocal lens: You can chose to have a multifocal or presbyopia reducing lens implant to correct the condition of presbyopia. These types of lenses often give both distance and near vision or emphasize distance and intermediate vision. Most that choose a multifocal lens option feel like they need glasses less than before and many state that they never wear glasses again. The multifocal lens implant gives people the highest chance of freedom from glasses. However, choosing a multifocal lens does not guarantee complete spectacle freedom. You may still need glasses for your best vision at distance and/or near. This lens is not a covered expense by your insurance company.

Astigmatic Correction lenses: You can choose to have an astigmatic correcting lens to reduce or correct your condition of astigmatism. These lenses may help to decrease your need for glasses for either distance or near tasks but typically not for both. Additional corneal procedures, glasses, or contact lenses may be needed to enhance or correct any residual astigmatism. I understand that if I have the condition of astigmatism, a single focus or monofocal lens will likely leave me with blurred vision at all distances without glasses or contact lenses. This lens is not a covered expense by your insurance company.

Custom Astigmatic Reduction Surgery:

LenSx Femtosecond Laser: You can choose to have LenSx Femtosecond Laser to correct your astigmatism. This is the most advanced technology available to correct astigmatism. A laser is used to create corneal incisions that can eliminate your astigmatism. The precision and accuracy of the LenSx Femtosecond Laser that creates these incisions allow additional advanced management of your astigmatism. This procedure is not a covered expense by your insurance company.

Manual Limbal Relaxation incisions: You can choose to have your astigmatism corrected by incisions created by your surgeon with a blade. One or more incisions are created in the cornea in an attempt to reduce your astigmatism. This procedure is not a covered expense by your insurance company.

Risks:

I understand that medicine and surgery are not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the planned surgery. I understand that one cannot be certain ahead of time how much improvement, if any, there will be in my vision without glasses. I understand that glasses may still be necessary for reading, distance vision or both and, in rare instances, surgical replacement of the implanted IOL may be indicated. The surgeon has discussed the risks of the planned surgery with me and has answered all of my questions. I understand that complication are rare and include but are not limited to:

- Anesthetic and/or drug reaction
- Astigmatism
- Bleeding
- Clouding / swelling of cornea
- Dislocation / malfunction of IOL
- Double vision
- Failure to improve vision
- Glare and / or halos
- Glaucoma
- Incorrect IOL power
- Increased need for glasses
- Infection
- Inflamation
- Iris discoloration
- Loss of the eyeball
- Loss of vision – partial or total
- Low eye pressure
- Organ damage or death
- Pain
- Perforation of the eyeball
- Ptosis (droopy lid)
- Pupillary abnormality
- Retinal detachment
- Retinal swelling
- Scarring
- Vitreous detachment
- Vitreous floaters

I understand that I will be required to purchase and use certain eye drops before and after surgery and I agree to follow the recommended drop regimen that will be provided to me to the best of my ability.

MEASURING IMPLANT STRENGTH

Prior to surgery, the length of your eye must be measured in order to calculate the strength of the intraocular lens implant that you require. Our practice has evaluated the most modern instruments available for this test, and we use the technology that we have found to be the most accurate. A small instrument is placed in front of your eye, and this emits sound or light waves that travel to the back of the eye and then are reflected back to the instrument. The computer receives the waves as they return, and automatically calculates the length of the eye.

While this test is very accurate in the vast majority of patients, some inaccuracy may occasionally occur. This is usually caused by an abnormal eye contour that causes scattering of the waves. The measurement of the length of the eye then becomes more of an estimate, and this may mean that the intraocular lens strength recommended by the computer is not totally accurate. Also, the effect of the implant on your vision can vary depending upon another factor that is not completely predictable. As the eye heals, the implant can shift very slightly toward the front or back of the eye. The amount of this shift is not the same for everyone, and may cause you to see differently than predicted by the measurements before surgery.

These problems occur only in a small percentage of patients, and are usually solved simply by wearing glasses that may be somewhat different from those that were expected to be necessary to complete the focusing of light rays. For those patients who do not wish to do this, a laser vision correction procedure such as LASIK or PRK is often performed. Note that an additional fee that is not reimbursable by health insurance plans would be charged for this.

Rarely, the implant strength may be inaccurate to the extent that surgical replacement of the implant is the best method to correct the situation. Fortunately, even in these rare circumstances, this replacement is usually simple. Furthermore, the true implant strength required is easily determined in such a situation, and improved focusing of the light rays after implant replacement is very likely.

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