DAVID D. RICHARDSON, MD, INC.
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Consent for Co-Management After Eye Surgery

PATIENT'S NAME: _____

PATIENT CONFIRMATION

Dr. Richardson will be performing eye surgery on me. I am aware that in order for the eye to heal properly it is critical that I receive appropriate follow up care by an eye doctor. As I live far enough away from Dr. Richardson's office that it would be a hardship for me to continue care with him after surgery, I have chosen to follow up with a doctor nearer to my residence for post-operative care.

INITIAL THE FOLLOWING:

_____I understand that I must keep all appointment recommended by Dr. Richardson or my designated local eye doctor in order for the eye to heal properly from surgery.

_____I understand that not following up as recommended by Dr. Richardson or my designated local eye doctor could result in failure or the surgery, complications, or even loss of vision.

_____I understand that it is my responsibility to arrange for payment of post-operative services and testing with my designated local eye doctor. I understand that these visits and/or testing may not be covered by my insurance.

_____Though my post-op appointments may be scheduled with my designated local eye doctor, I understand that I may also contact Dr. Richardson at any time after the surgery. Dr. Richardson or a doctor covering him will be available to address any concerns I may have after surgery.

I have discussed this postoperative selection with Dr. Richardson and/or his representative.

_____ _____
Patient Signature Date

_____ _____
Witness Date

_____ _____
Designated Local Doctor Date

_____
Address of Local Doctor