Eyesight
Uncompromising Care

Patient: _____

AUTHORIZATION TO PERFORM SERVICES - Cataract Surgery with an upgrade

1. I have requested that my physician at Eyesight Ophthalmic Services perform my cataract surgery at Coastal Surgical Center. My lens selection is initialed below

2. I understand that should I choose Optiwave, Toric/Astigmatism Reducing or Presbyopia reducing upgraded lenses, **they are not covered benefits by my insurance company**, and will not be paid for by my insurance company.

3. My insurance will only be billed for basic surgery procedures, which do not include the extra costs for the lens implants or the extra professional fees associated with the planning and execution of the surgery. The surgery center will bill my insurance for the basic cataract items and I will be responsible for the extra costs associated with the upgraded lens implant itself. The fee for the professional component of the upgraded surgery due to Eyesight will be: (please circle and initial below):

	Optiwave Enhanced Vision	Toric Astigmatism Reducing	Presbyopia Reducing	Light Adjustable Lens (LAL or LAL+) / RLE	Basic Lens
Standard	$ 1,050.00	$ 1,950.00	$ 2,450.00	$ 3,300.00	Insurance deductible & copayment fees
Post Refractive Surgery	$ 1,050.00	$ 2,250.00	$ 2,750.00	$ 3,300.00	
Self-Pay/Cosmetic	$ 3,050.00	$ 3,950.00	$ 4,450.00	$ 5,300.00	$ 2,000.00
I CHOOSE THE FOLLOWING:	_____ ***If chosen, initial above***	_____ ***If chosen, initial above***	_____ ***If chosen, initial above***	_____ ***If chosen, initial above***	_____ ***If chosen, initial above***

Payable to Eyesight Ophthalmic Services **one week prior** to the surgical procedure. Amount may be paid in the form of cash, credit card or check. Extended and interest free financing options may be available through Care Credit (www.CareCredit.com).

My signature below indicates that I agree to accept responsibility for payment for the upgrade, if I have selected an upgrade, and will not seek payment from my insurance company.

I understand that my permission is voluntary, that I may withdraw consent at any time, without prejudice to my present or future care at Eyesight Ophthalmic Services.

In addition, I understand that no surgical procedure can be guaranteed, and that during surgery unforeseeable circumstances may arise. If I have chosen an Advanced lens, and should medical opinion dictate that the Advanced lens should not be implanted, I will be billed for basic cataract surgery.

_____ SIGNATURE OF PATIENT

_____ DATE

_____ SIGNATURE OF WITNESS

_____ DATE

Surgery Date _____ OD (right eye)
Lens: ☐Monofocal Toric ☐Panoptix-Panoptix Toric ☐Vivity-Vivity Toric ☐Optiwave Analysis ☐LAL ☐LAL+ ☐BASIC

Surgery Date _____ OS (left eye)
Lens: ☐Monofocal Toric ☐Panoptix-Panoptix Toric ☐Vivity-Vivity Toric ☐Optiwave Analysis ☐LAL ☐LAL+ ☐BASIC