Eyesight
Uncompromising Care

Please bring this book with you to all appointments.

BASIC LENS PROCEDURES

PREPARING FOR YOUR CATARACT PROCEDURE BEFORE / DURING /AFTER

Name: _____ DOB: _____

This book is in reference to surgery on your ☐ RIGHT ☐ LEFT eye

DATE OF SURGERY: _____ **Surgeon:** _____

ARRIVAL TIME: **Eyesight does not schedule your surgery time**. You will be contacted by the surgery center the day before your procedure with your expected arrival time. **You will also be called 1-2 weeks prior to surgery to go over your medical history. If you have not heard from the surgery center by 3:30pm the day before your procedure, please contact them directly at 603-314-8035 to get your time.** Eyesight staff may not be aware of your arrival time.

Note: The first 2 pages of this book offer a convenient overview of items covered in this book.

SURGERY CENTER / LOCATION OF SURGERY:

☐ **Coastal Surgical Center – 291 Shattuck Way, Newington NH – 603-314-8035**

Alternative locations:

☐ Frisbie Memorial Hospital - 11 Whitehall Road, Rochester NH - 603-330-8936
☐ Wentworth Douglass Hospital - 789 Central Avenue, Dover NH - 603-740-2281
☐ Exeter Hospital - 5 Alumni Drive, Exeter NH – 603-580-7568

AFTER SURGERY APPOINTMENTS: **YOU MUST BE SEEN FOR A FOLLOW UP APPOINTMENT AFTER SURGERY. PLEASE PLAN TO SEE US AT EYESIGHT ON THE FOLLOWING DATE/TIME:**

1st post-op appointment is in the ☐ PORTSMOUTH ☐ SOMERSWORTH ☐ EXETER ☐ KITTERY

Eyesight office on_____ at _____with Dr._____.

2nd post-op appointment is in the ☐ PORTSMOUTH ☐ SOMERSWORTH ☐ EXETER ☐ KITTERY

Eyesight office on_____ at _____with Dr._____.

PREPARING FOR YOUR CATARACT EVALUATION

By now, you've met with a counselor for a pre-evaluation to discuss lens options. Our premium lenses may significantly reduce or eliminate your need for glasses, which will be further addressed during your full evaluation with the doctor. They will review test results from your pre-evaluation, which include:

- **Biometry Tests:** To calculate the power of the artificial lens that will be implanted.
- **Optical Coherence Tomography (OCT):** To assess the health of your macula.
- **Corneal Topography:** A color-coded map that shows the shape and contour of your cornea. This test is especially important for patients with astigmatism, previous LASIK, or those considering premium lenses.

Pre-Cataract counselors

Victoria	PORTSMOUTH	603-501-7868 x243	Vbrown@EyesightNH.com
Staci	PORTSMOUTH	603-501-7868 x603	Sbenjamin@EyesightNH.com
Lisa	SOMERSWORTH	603-501-7868 x214	Lbergeron@EyesightNH.com

WHAT TO BRING TO YOUR CATARACT EVALUATION / MEETING YOUR SURGEON

- **This Book with Your Forms:** Pages 12 and/or 13 and the Informed consent pages in the back. ***PLEASE FILL THIS OUT COMPLETELY UNTIL YOU REACH THE "STOP SIGN" PAGE,*** *which is labeled "Lens Choice and Informed Consent for Cataract Surgery".* ***This portion is filled out with your surgeon.***
- **Medication List:** Include all prescriptions, over-the-counter meds, vitamins, and supplements.
- **Provider Contact Info:** Your Primary Care Provider (PCP) and Cardiologist (if you have one)
- **Family member or friend:** Having someone with you can help remember important information.
- **Transportation:** If unsure about driving post-dilation, plan for a ride
- **Eye Drops:** If you have dry eyes use artificial tears 4x/day for 2 weeks
- **Documentation:** Bring any necessary health proxy, power of attorney, or translator documents.
- **Glasses:** Please bring any glasses you wear on a daily basis
- **Your calendar:** To help schedule your surgery dates. If you do not meet with a coordinator, or are not ready to schedule after the evaluation, expect a call within two weeks to discuss your surgery options and the possibility of scheduling surgery date(s) with follow-up appointments.
- **Stay out of contact lenses:** This ensures accurate measurements of your eyes
    - **Soft contact lenses:** **Remove 1 week prior**
    - **Toric contact lenses:** **Remove 2 weeks prior**
    - **Hard contact lenses (RGP):** **Remove 3 weeks prior**

WHAT TYPE OF LENS OPTIONS ARE AVAILABLE?

During surgery, your cloudy cataract is removed and replaced with an artificial lens. Your surgeon will discuss which artificial lens best aligns with your vision goals. Not everyone is a good candidate for all lenses.

Ranges of vision:		
Distance vision:	6+ feet away	Road signs, TV
Intermediate vision:	Arm's length	Car dashboard, computer
Near vision:	2-16" away	Reading, phone

BASIC LENS: "I am fine wearing glasses full-time"

This is the only lens that is covered by your insurance company. If you pick a distance lens, and have an astigmatism, you will likely still need prescription glasses for your best distance vision and will also need glasses for intermediate and near.

(If you are near-sighted and want to stay this way, you may pick a basic lens for near vision. You will need prescription glasses for distance)

OPTIWAVE REFRACTIVE ANALYSIS (ORA): "I want to see clearly at ONE RANGE (distance, intermediate or near) without glasses, and I will wear glasses for all other ranges"

If you don't have astigmatism and you'd like to maximize vision at ONE RANGE without glasses, ORA will improve the accuracy of your outcome by obtaining additional measurements during surgery. This is especially beneficial if you've had prior LASIK or have a denser cataract.

If you pick distance vision, you will need over-the-counter readers for intermediate and near. If you pick near vision, you will need prescription glasses for distance and intermediate.

TORIC LENS: "I have an astigmatism and I want to see clearly at ONE RANGE (distance, intermediate or near) without glasses. I will wear glasses for all other ranges"

If you have astigmatism and you'd like to maximize vision at ONE RANGE without glasses, you will need a toric lens. If you pick distance vision, you will need over-the-counter readers for intermediate and near. If you pick near vision, you will need prescription glasses for distance and intermediate.

Note: If you have tried monovision in the past and liked it (one eye distance, one eye near), this can be reproduced surgically. We do recommend ORA or a toric lens (if you have astigmatism) for best results.

PRESBYOPIC LENS (I.E. PANOPTIX, VIVITY): "I want to see clearly for a range of distances with reduced need for glasses"

PanOptix: Provides best range of vision, will need readers for fine print. Can cause night-time glare and halos

Vivity: Provides excellent distance and intermediate. Will need readers for near

LIGHT ADJUSTABLE LENS (LAL and LAL+): "I want a lens that I can test drive after surgery and fine tune it"

Each lens provides moderate range of vision. You can trial blended vision (one eye for distance, other eye for near). It can be adjusted after surgery to maximize accuracy. Always requires 3-5 additional dilated post-operative visits and UV glasses until the lens is locked.

SURGERY CHECKLIST

- ☐ **Make sure you know the date(s) for your surgery.**
  - If you are only having one eye treated, you should have 1 copy of this book.
  - If you are having 2 eyes treated, you should have 2 copies of this book.
  - Eyesight employees do not schedule the time for your surgery. That is done by the surgery center.

- ☐ **Make sure you know the date, time, and location of your follow-up appointments.**
  - Your first appointment usually occurs the day of or the day after your surgery
  - Additional appointments depend on your healing and your eye health. These may be with your surgeon or with your regular eye doctor

- ☐ **Make sure you have turned in all your consent forms. We cannot schedule your surgery until you have signed:**
  - "Informed Consent for Cataract Surgery".
  - "Lens Choice and Informed Consent for Cataract Surgery" (this was the form you signed with your surgeon at your Cataract Evaluation).
  - Additional forms, such as Health Plan Denials and Personal Obligation / Cash Pay (pg. 13), may be required if you do not have insurance.

- ☐ **If you have a Health Proxy, Power of Attorney, require a translator, or need additional support for surgery,** please make sure we have this information on file. Your surgery center may also require a copy.

- ☐ **If you have a cardiologist or a PCP who needs to approve your surgery,** please make sure we have their contact information and/or written documentation authorizing you to proceed with surgery.

1- 2 WEEKS PRIOR TO SURGERY

- **Make sure you have your medicated eye drops**
  After cataract surgery, patients need to use several different prescription eye drops to help prevent infection, reduce inflammation, and manage discomfort. These drops are usually taken on different schedules, which can be confusing. To make things easier, we offer a convenient option called Imprimis—a single eye drop that combines all the necessary medications into one. This helps simplify your routine and makes it easier to follow the treatment plan.

  - Imprimis is not covered by insurance, but the cost is typically similar to what you'd pay in co-pays for three separate prescription drops.
  - If you've selected the Basic Lens package, Imprimis must be purchased separately before surgery.
  - Regardless of whether you are using Imprimis or traditional prescription drops, all eye drops must be picked up before your surgery. Imprimis is available for purchase or pickup at the front desk of any Eyesight location. Prescriptions will be called into your pharmacy.
  - **If you regularly use other prescription eyedrops**, please consult with your surgeon regarding their use before or after, surgery.

- You may continue to wear contact lenses.

1-2 BUSINESS DAYS PRIOR TO SURGERY

You will receive a call from the surgical center with your arrival time and to answer medical related questions.

- They will discuss your medical history and your current medications
- They will review if you need to stop your insulin or diabetes medications
- They will review if you need to stop your GLP-1 agonist (ex. Ozempic, Wegovy, Mounjaro)

DAY BEFORE SURGERY

- **Do not eat or drink anything after midnight** or your surgery will be canceled
  - This includes coffee, toast, juice, gum, etc.
  - You may brush your teeth but rinse/spit

- On the night before surgery **take a shower or bath and wash your hair thoroughly**

DAY OF SURGERY

- **Start your eye drops** (either Imprimis or the 3 separate drops) 1 hour prior to leaving the house
  - If using Imprimis, **see page 7**
  - If using the 3 separate drops, **see page 8**
  - **If you use Xiidra, Restasis or Cequa**, use 1 drop the morning of surgery, and then resume 1 week AFTER SURGERY.

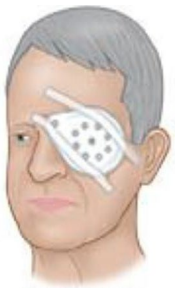
- Medications may be taken with a **sip** of water
- **Bring your surgery bag, eye drops, and your sunglasses or prescription glasses with you**
- **Wear loose-fitting clothing** (button-down shirt is best) and slip on shoes (no lace-up boots)
- **Wash your face** with soap and water and make sure you remove any mascara or eyeliner
- **No makeup, jewelry, nail polish, hairspray, perfume/cologne, or lotions.** Deodorant is okay
- **You need a responsible adult (18 or over) who is known to you (i.e. family, friend, neighbor) to accompany you to and from surgery**. You will be asked to identify this person prior to surgery. You may use taxis, Ubers, etc. for your surgery if you have a responsible adult with you.
- **If you would like to receive IV sedation, you need someone to stay with you for 24 hours after surgery**. You may also choose to have numbing drops only, without IV sedation

AT THE SURGERY CENTER / HOSPITAL

- After checking in, you will be brought to the “short stay” area of the surgery center. Your anesthesia provider and your surgeon will speak with you and have you sign consent forms
- You will have an intravenous (IV) line placed in your arm. The sedation usually consists of an anti-anxiety medication called Versed (midazolam) and sometimes an opioid called fentanyl
- You will receive several rounds of eye drops (dilation, numbing, antibiotic)
- You will be at the surgery center for ~1-2 hours. The surgery itself usually takes about 20 minutes

AFTER SURGERY

- It is normal for your eye to be blurry, watery, and have mild discomfort
- You may take ibuprofen (Advil) and acetaminophen (Tylenol)
- Be gentle with your eye – no pushing or rubbing


Eye shield

For 1 week after surgery:

- Wear the protective eye shield any time you're sleeping
- No eye makeup (eyeliner, mascara, eyeshadow)
- No physically strenuous activity (lifting more than 35 lbs)

For 2 weeks after surgery:

- No high-impact sports or activities (skiing, tennis, pickleball, etc.)
- In general, we recommend no traveling more than 2 hours away in case urgent issues arise

For 3 weeks after surgery:

- No swimming underwater (even with goggles on)

It is safe to:

- Shower and bathe like normal
- Read and watch TV
- Walk, be outdoors, do light housework
- Bend over to put on a pair of shoes or pick up something light (<35 lbs)

Can I use my other eye drops?

- Please discuss your specific situation with your surgeon

PLEASE CALL US IMMEDIATELY IF YOU NOTICE SIGNIFICANT WORSENING OF VISION OR PAIN.

WE ALWAYS HAVE AN MD ON-CALL WHO CAN HELP YOU.
CALL THE MAIN OFFICE LINE AT 603-436-1773.

THE AFTER-HOURS GREETING WILL INCLUDE THE OPTION TO REACH THE MD ON CALL.

Imprimis / Combo Drop Schedule

IMPRIMIS *Prednisolone-Moxifloxacin-Nepafenac*

Additional artificial tears/lubricating drops are recommended

Have Drops Ready: For each eye you will have 1 bottle of Imprimis (if receiving an upgrade). These drops can be picked up at any Eyesight office. Imprimis is **not** available at the surgery center or your pharmacy.

Morning of Surgery: Starting 1 hour before leaving home, use Imprimis eye drop every 15 minutes for a total of 4 doses. i.e. if you will be leaving home at 9:00 AM, use Imprimis at 8:00, 8:15, 8:30, and 8:45 AM. This applies **regardless of your drive time** to the surgery center.

Shake bottles before use. The Imprimis drop comes out quickly – tip bottle upside down and wait for drop to come out or tap the bottle gently **DO NOT SQUEEZE THE BOTTLE**. **Space out all drops by at least 5 minutes**. Do not share bottles between two eyes.

Beginning 1 HOUR BEFORE LEAVING HOME FOR THE SURGERY CENTER on_____

1 hour prior	45 minutes prior	30 minutes prior	15 minutes prior
☐	☐	☐	☐

After leaving the surgery center, use again at 12:00pm – 4:00pm – 8:00pm
☐ ☐ ☐

After Surgery: ***(4 times a day is roughly 8am, 12pm, 4pm, 8pm. 2 times a day is roughly 8am and 8pm)***

Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
IMPRIMIS	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐

Week 2	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
IMPRIMIS	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐	4 times a day ☐ ☐ ☐ ☐
Artificial Tears	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐

Week 3	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
IMPRIMIS	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐
Artificial Tears	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐

Week 4	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28
IMPRIMIS	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐
Artificial Tears	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐	2 times a day ☐ ☐

Please bring your eye drops and this schedule to the surgery center and to all follow-up appointments.

Separate Drop Schedule

For each eye you will be prescribed 3 drops to your pharmacy. Drops are **not** available at the surgery center. To keep your eyes moist, we recommend purchasing lubricating drops. Coupons are available at all Eyesight locations.

Morning of Surgery: Starting 1 hour before leaving home, use 1 drop each of the moxifloxacin, prednisolone, and ketorolac every 15 minutes for a total of 4 doses. i.e. if you will be leaving home at 9:00 AM, use the drops at 8:00, 8:15, 8:30, and 8:45 AM. Shake bottles before use. **Separate drops by at least 5 minutes**. Do not share bottles between eyes.

Beginning 1 HOUR BEFORE LEAVING HOME FOR THE SURGERY CENTER on _____

1 hour prior	45 minutes prior	30 minutes prior	15 minutes prior
☐	☐	☐	☐

After leaving the surgery center, use again at 12:00pm – 4:00pm – 8:00pm
☐ ☐ ☐

After Surgery: (4 times a day is roughly 8am, 12pm, 4pm, 8pm. 2 times a day is roughly 8am and 8pm)

Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Moxifloxacin or Polytrim	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □
Prednisolone Acetate 1%	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □
Ketorolac	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □

Week 2	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Prednisolone Acetate 1%	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □
Ketorolac	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □	4 times a day □ □ □ □
Artificial Tears	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □

Week 3	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
Prednisolone Acetate 1%	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □
Ketorolac	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □
Artificial Tears	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □

Week 4	Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28
Prednisolone Acetate 1%	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □
Ketorolac	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □
Artificial Tears	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □

It is EXTREMELY important to follow your eyedrop instructions!
NOTE: Your surgeon will discuss the recommended continuation of your eyedrops after 4 weeks

Week 5 & Week 6	Day 29	Day 30	Day 31	Day 32	Day 33	Day 34	Day 35
Prednisolone Acetate 1%	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □
Ketorolac Tromethamine	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □
Artificial Tears	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □	2 times a day □ □

Your procedure is scheduled for Coastal Surgical Center. If your procedure location is changed, our office will notify you.

DIRECTIONS

COASTAL SURGICAL CENTER
291 Shattuck Way
Newington, NH 03801
Phone: 603-314-8035

Traveling North: Take I-95 to Exit 4 on the left for US-4/NH-16 toward White Mountains. Keep left, follow signs for Newington/Dover/US-4/NH-16/ White Mountains. Take Exit 4 for Shattuck Way toward Newington Village. Turn right onto Shattuck Way. The surgical center is located 0.7 miles down the road on the right side with ample parking.

Traveling South: Take Spaulding Turnpike/NH-16. Take Exit 4 for US-4/NH-16 N toward Newington Village/Historic Sites/Dover/Concord. Continue 0.2 miles onto Nimble Hill Road and pass under Route 16. Turn right on Shattuck Way. The surgical center is located 1.5 miles down the road on the right side with ample parking.

*__You must have__ a responsible adult designated to accompany you to and from surgery. You will be asked to identify this person prior to surgery. Do not plan to use taxis, Ubers, or other public transportation for your procedures unless you also have a responsible adult with you.

***Anesthesia requires that someone stay with you for 24 hours after surgery**.

COASTAL
SURGICAL CENTER

UNDERSTANDING THE COSTS RELATED TO YOUR UPCOMING SURGERY

Cataract Surgery Coverage:

- Basic cataract surgery is typically covered by your medical insurance if you have visually significant cataracts that affect your daily life.
- This means that the procedure itself is considered medically necessary, and your insurance will help cover the costs.

Copays and Deductibles:

- Even though your surgery may be covered by insurance, you may still have to pay a **copay** (a fixed fee for the service) and a **deductible** (the amount you pay out-of-pocket before insurance starts covering costs).
- These fees are standard in many insurance plans and apply to various medical procedures, including cataract surgery.

Premium Lens Upgrades:

- If you choose a premium lens upgrade or service such as Optiwave, Toric Lens, Presbyopic Lens or a Light Adjustable Lens (LAL), these options provide additional benefits, such as improved vision at multiple distances.
- Since these premium lenses are considered enhancements beyond basic coverage, you will be responsible for the full cost of the upgrade.

Billing Process:

- We will bill your insurance for the cataract surgery, regardless of your lens choice.

  That is considered the cost of the procedure itself.
- However, the costs for the premium lens upgrade will be billed separately, as they are not covered by insurance.

Concerned about coverage? Contact your insurance plan prior to surgery.

This is always the BEST way to ensure you will not have unexpected charges after your procedure, particularly for copays and deductibles. **You will receive charges from BOTH Eyesight AND the SURGICAL CENTER**. Your insurance plan will need to know the following:

What is the CPT code for your procedure? (this code is used for both the physician and surgery center)

66984 – Cataract Surgery or 66982 for Complex Cataract Surgery

For Glaucoma patients :

iStent or Hydrus: 66991 for Standard or 66989 for Complex
Goniotomy: 65820 - Incision Procedures on the Anterior Chamber of the Eye
iDose: 0660T

At the surgery center, for pain after surgery and to minimize inflammation, your surgeon may use:
Dextenza (a dexamethasone insert) –J1096 (4 units)

What is the NPI number of the practice?

Eyesight Ophthalmic Services (for physician fees, follow up care, evaluations, etc.)
NPI: 1073736310

Coastal Surgical Center (for surgery, lenses, etc.)
NPI: 1336713890

They will likely provide you with a reference number. Please write that number down:

Reference / Prior Authorization Number_____

SURGICAL FEE SCHEDULE (PER EYE)

BASIC CATARACT PACKAGE *(per eye)*

This is the best option if you do not mind wearing glasses after cataract surgery. Most of the costs of Basic Cataract Surgery are covered by Medicare and other insurance companies. However, in addition to any deductibles, copayments and coinsurances required by the insurance company, the patient may have financial responsibility for additional testing recommended by their surgeon

	STANDARD	POST-LASIK	SELF PAY
EYESIGHT FEES			
PHYSICIAN SURGICAL FEE	Insurance fees	Insurance fees	$ 2,000.00
EXAM FEE (collected during the 1st pre-operative exam)	Insurance fees	Insurance fees	$ 500.00
TOTAL COLLECTED BY EYESIGHT	**$ Insurance Fees**	**$ Insurance Fees**	**$ 2,500.00**
COASTAL SURGICAL CENTER FEES			
FACILITY FEE	Insurance fees	Insurance fees	$ 1,400.00
LENS FEE	Insurance fees	Insurance fees	$ 65.00
ANESTHESIA FEE	Insurance fees	Insurance fees	$ 560.00
TOTAL COLLECTED BY COASTAL SURGICAL CENTER	**$ Insurance Fees**	**$ Insurance Fees**	**$ 2,025.00**
TOTAL FEES FOR BASIC CATARACT by Eyesight & Coastal Surgical Center	**$ Insurance Fees**	**$ Insurance Fees**	**$ 4,525.00**

Includes: Pre and Intraoperative Planning and 3 months of postoperative care. **Patient Responsibility:** Insurance deductible, co-pay & coinsurance, and pre/post-operative eyedrops.

CREDIT CARD POLICY AT COASTAL SURGICAL CENTER: At the time of registration, they'll ask for a credit card and store the info safely. After your insurance pays its part, you'll have 30 days to pay what's left. If you don't, they'll charge the card you gave them.. Co-pays must be paid at the time of visit.

SURGERY CONTACT INFORMATION

Coastal Surgical Center - 291 Shattuck Way, Newington NH — 603-314-8035 (before 4:30pm)

Wentworth Douglass Hospital – 789 Central Avenue, Dover NH — 603-740-2281 (after 6pm 603-740-2433)

Frisbie Memorial Hospital - 11 Whitehall Road, Rochester NH — 603-330-8936 (after 5pm 603-332-5211)

Exeter Hospital - 5 Alumni Drive, Exeter NH — 603-580-7568 (before 4:30pm)

Or contact your Eyesight surgical coordinator if you have any questions by dialing 603-501-7868 and the extension

PORTSMOUTH COORDINATORS:
Sandy x230 Leah B. x240 Heather x317 Phyllis x805

EXETER COORDINATORS:
Casey X207

SOMERSWORTH COORDINATORS:
Cassie x263 Kimberly x541 Leah S. x631 Heather x317 Phyllis x805

KITTERY COORDINATORS:
Leah S. x631

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+)	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. The 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

COASTAL SURGICAL CENTER

Cataract Surgery with Advanced Presbyopia, Monofocal, Toric, or Light Adjustable Intraocular Lens

Health Plan Denials and Personal Obligation / Cash Pay

Your carrier will only pay the surgery center if the services you receive are covered under the terms and conditions of your Health Plan. Your benefits may be denied or reduced by your plan if the plan believes:

• the services are not medically necessary;	• the services are not ordered/performed by a participating physician;
• the procedure or test is a non-covered service	• the services are not provided in a participating facility;
• health plan pre-authorization requirements were not met:	• the insurance plan does not provide benefits for the patient.

Health Plans review surgical services to determine if the services are covered under policy benefits. The term "Medically Necessary," for most plans usually means services which are:

- appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition
- within recognized standards of medical practice
- not primarily for the convenience of the member, the member's family and/or the physician
- the least costly of alternative supplies or levels of service, which can be safely and effectively provided to the patient

At this time, the specialty lens that will be used for your surgery is not a covered service by your healthcare plan. Payment for the lens must be received at least 1 week prior to the date of your surgery for the following amounts: **Please initial below your choice:**

Per eye prices

	BASIC AND / OR OPTIWAVE ENHANCED			PRESBYOPIA REDUCTION		
	STANDARD	POST-LASIK	SELF PAY	STANDARD	POST-LASIK	SELF PAY
FACILITY FEE	Insurance fees	Insurance fees	$ 1,400.00	Insurance fees	Insurance fees	$ 1,400.00
LENS FEE	Insurance fees	Insurance fees	$ 65.00	$ 950.00	$ 950.00	$ 950.00
ANESTHESIA FEE	Insurance fees	Insurance fees	$ 560.00	Insurance fees	Insurance fees	$ 560.00
TOTAL	Insurance fees	Insurance fees	$ 2,025.00	$ 950.00 + Insurance fees	$ 950.00 + Insurance fees	$ 2,910.00
	_____	_____	_____	_____	_____	_____

	ASTIGMATISM / TORIC			LIGHT ADJUSTABLE LENS	
	STANDARD	POST-LASIK	SELF PAY	STANDARD	SELF PAY
FACILITY FEE	Insurance fees	Insurance fees	$ 1,400.00	Insurance fees	$ 1,400.00
LENS FEE	$ 450.00	$ 450.00	$ 450.00	$ 1,100.00	$ 1,100.00
ANESTHESIA FEE	Insurance fees	Insurance fees	$ 560.00	Insurance fees	$ 560.00
TOTAL	$ 450.00 + Insurance fees	$ 450.00 + Insurance fees	$ 2,410.00	$ 1,100.00 + Insurance fees	$ 3,060.00
	_____	_____	_____	_____	_____

Your financial agreement with the surgery center is to pay for all services you receive, even those denied by your Health Plan. This agreement is a promise to pay for all services, to the extent not paid by some other party on your behalf

The undersigned certifies that he/she has read the above, accepts financial responsibility for amounts listed above, and is the patient, the patient's agent, insured or guarantor.

_____ _____

Patient, Insured or Guarantor | Name of Patient

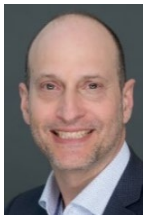
_____ _____

Witness | Date

PAYMENT IS DUE A MINIMUM OF 1 WEEK PRIOR TO SURGERY – COASTAL SURGICAL WILL CONTACT YOU TO COLLECT PAYMENT

PAYMENT OPTIONS: Interest-free financing available for up to 24 months and extended payment plans are available through www.CareCredit.com. We also accept MasterCard, Visa, Discover, Cash or Check to COASTAL SURGICAL CENTER.

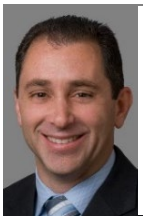
Your family of Eyesight staff is here to assist you with every aspect of caring for your eyes.



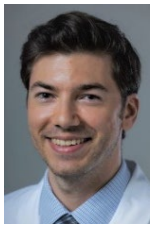
Warren Goldblatt, MD

Jennifer Ling, MD

Christopher Turner, OD

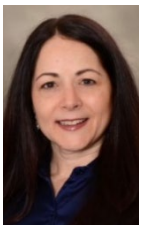


N. Timothy Peters, MD



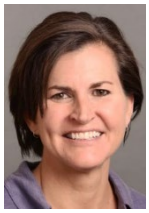
Jason Szelog, MD

Lauren McLoughlin, OD



Marsha Kavanagh, MD

Nathaniel Sears, MD

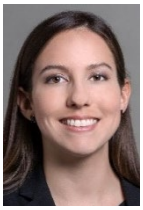


Janet Rand, OD

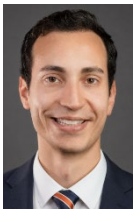
Timothy Sullivan, MD

Dana Graichen, MD

Renee Lynch, OD

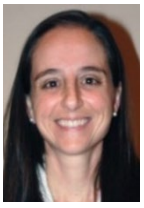


Claudia Bartolini, MD



Jonah Goldblatt, MD

Hilary Hamer, OD



Kinley Beck, MD

Qingjie Wang, MD

Dwight Arvidson, OD

Greg Marrow, OD

PORTSMOUTH
155 Borthwick Avenue, Suite 200 East - Portsmouth, NH 03801
Tel: (603) 436-1773 Fax: (603) 427-0655

SOMERSWORTH
267 Route 108 - Somersworth, NH 03878
Tel: (603) 692-7500 Fax: (603) 692-7575

EXETER
71 Portsmouth Ave #101 - Exeter, NH 03833
Tel: (603) 778-1133 Fax: (603) 778-1055

KITTERY, ME
99 US-1, Suite B - Kittery, ME 03904
Tel: (207) 439-4958 Fax: (207) 439-4313

SANFORD, ME
272 Cottage Street – Sanford, ME 04073
Tel: (207) 324-3380 Fax: (207) 490-9174

www.EyesightNH.com

Informed Consent for Cataract Surgery

This information is given to you to help you make an informed decision about having cataract and/or lens implant surgery. **You will live with the vision resulting from your decisions for the rest of your life, so please read the following explanations carefully.** Once you have read this Informed Consent, you are encouraged to ask any questions you may still have about the procedure. This document will help you understand the risks of cataract surgery.

WHAT IS A CATARACT?

The natural lens in the eye can become cloudy and hard, a condition known as a cataract. Cataracts can develop from normal aging, from an eye injury, or if you have taken medications known as steroids. As a cataract develops, it blocks and scatters light, reducing the quality of vision. Cataracts may cause blurred vision, dull vision, sensitivity to light and glare, and/or ghost images. If the cataract changes vision so much that it interferes with your daily life, the cataract may need to be removed. Surgery is the only way to remove a cataract. You can decide not to have the cataract removed. If you don't have the surgery, your vision loss from the cataract may continue to get worse.

HOW WILL REMOVING THE CATARACT AFFECT MY VISION?

The goal of cataract surgery is to correct the decreased vision that was caused by the cataract. Cataract surgery will not correct other causes of decreased vision, such as glaucoma, diabetes, or age-related macular degeneration. During the surgery, the ophthalmologist (eye surgeon) removes the cataract and typically puts in a new artificial lens called an Intra-Ocular Lens (IOL).

UNDERSTANDING THE MAJOR RISKS OF CATARACT SURGERY

1. RISKS OF THE SURGERY: All operations involve risk and may have unsuccessful results, complications, or injury. Problems with cataract surgery are very rare. There are complications in **FEWER** than 1 in 1,000 of cataract surgeries. Complications may occur weeks, months or even years after surgery.

Problems, while extremely rare, include, but are not limited to, discomfort or pain, droopy eyelids, bleeding; infection; clouding of the outer part of the eye (called the cornea); swelling of the inside layer of the eye (called the retina); detachment of the retina from the eye; increased eye pressure which is also called "glaucoma"; damage to the tissue that supports the lens placed into the eye; and retained pieces of cataract that remain in the eye after surgery. If complications occur, the doctor may decide not to implant the lens in your eye and additional surgeries may be needed. These problems may lead to worse vision, total loss of vision, or even loss of the eye in rare situations.

Dextenza (www.Dextenza.com) is an FDA approved, preservative free, dissolvable, implant, which may be used for certain patients during cataract surgery to reduce pain and/or swelling. Use of Dextenza may help reduce the length of time required for surgical eyedrops to be used postoperatively / after cataract surgery.

Depending on the type of anesthesia, other risks are possible, just like any other surgery, including heart and breathing problems, and, in extremely rare cases, death.

*Initials*_____

Additional surgery may be necessary, even when there are no complications with cataract surgery. You may need a laser surgery to correct clouding of the capsule directly behind the lens (also called a YAG).

At some future time, the lens in your eye may move as a result of the natural aging of the eye, and, although rare, may need to be repositioned with an additional surgery.

2. ISSUES ASSOCIATED WITH THE IMPLANT: Prior to cataract surgery, your eye must be measured to determine the strength of the lens that you require. While this test is very accurate for the majority of patients, some inaccuracies may occur. This problem occurs in only a small percentage of patients, but it would cause the prescription of the eye after cataract surgery to be different than what was expected. Wearing eyeglasses or contact lenses usually solves this. In extremely rare situations, the lens may need to be replaced to correct the strength of the lens.

After cataract surgery it is not uncommon for vision to have some dark shadowing or an “arc” of light in the outer part of the vision. This is called a "dysphotopsia". It is usually temporary and usually resolves on its own. Depending on the type of lens implanted, you may have higher rates of night glare or halos, double vision, impaired depth perception, blurry vision, or trouble driving at night.

3. Cataract surgery is performed one eye at a time. During the time between surgeries, there can be an imbalance between the eyes that can make glasses not work well. This imbalance can cause eye strain and tired eyes. Surgery in the second eye can fix this.

4. There are other eye problems that can affect vision after surgery, like glaucoma, diabetes in the eye, macular degeneration, or your individual healing after surgery. The results of surgery cannot be guaranteed. There is no guarantee of "20/20 vision."

*Initials*_____

PATIENT CONSENT

Please copy the following sentences, as they appear, prior to the consultation.

"I understand there are risks of surgery including vision loss."

_____

_____

"I understand I may need more than one surgery per eye."

_____

_____

"I understand I may not have 20/20 vision after surgery."

_____

_____

_____	_____	_____
Patient name (printed)	Patient Signature	Date

If cataract surgery is scheduled, I authorize the following individuals to communicate with the surgical center on my behalf. However, I understand that only I can answer medical questions unless a medical DPOA is active and on file.

Name of person	Relationship to patient	Phone Number
Name of person	Relationship to patient	Phone Number

Representatives may be from Coastal Surgical Center, Wentworth Douglass Hospital, Frisbie Memorial Hospital, or Exeter Hospital depending on where my procedure is scheduled.

After your Cataract Evaluation, you may want to schedule surgery. To help us schedule your surgery at the appropriate location, please fill out the questionnaire below. Your surgeon will review your answers during your cataract evaluation.

Eyesight Uncompromising Care

ANESTHESIA QUESTIONNAIRE

REQUIRED FOR ALL SURGERY PATIENTS PRIOR TO SEEING YOUR SURGEON

Name_____ Date_____

Name of PCP Cardiologist Optometrist

1. Have you had any cardiac event within the last 60 days (including heart attack/MI, cardiac stent placement, or cardiac bypass surgery)?	☐ Yes	☐ No
If yes, date of cardiac event:	_____	
2. Have you had a stroke or TIA (mini stroke) in the last 3 months?	☐ Yes	☐ No
If yes, date of stroke or TIA (mini stroke):		
3. In the last 3 months, have you had any sort of seizure?	☐ Yes	☐ No
If yes, date of seizure?	_____	
Are you taking any medication to prevent a seizure?	☐ Yes	☐ No
If yes, what is the name of the seizure medication?	_____	
4. Are you currently undergoing medical workup for chest pain, shortness of breath, abnormal heart rhythm, heart valve conditions, seizures, strokes/TIA (mini strokes), or a clotting disorder?	☐ Yes	☐ No
If you are currently being worked up for these conditions, when do you anticipate completing your evaluation?	_____	
5 . Do you have difficulty lying flat on your back without discomfort or difficulty breathing?	☐ Yes	☐ No
6. What is your height?	_____ft	_____in
What is your most recent weight?	_____ lbs.	
7. Do you take Wegovy, Ozempic, Mounjaro, or other GLP-1's?	☐ Yes	☐ No
8. Do you require continuous oxygen therapy for any breathing disorder (for example COPD, emphysema, pulmonary fibrosis)?	☐ Yes	☐ No
9. Are you currently on any form of dialysis?	☐ Yes	☐ No
10. Do you have difficulty with shortness of breath or weakness doing everyday activities (such as walking, cleaning, showering, etc.?)	☐ Yes	☐ No
11. Have you been to a cardiologist in the last 3 years?	☐ Yes	☐ No
If yes, for what reason?	_____	
12. Have you been hospitalized or evaluated in the ER for any reason within the last month?	☐ Yes	☐ No
If yes, then where?	_____	
13. Are you currently receiving radiation or chemotherapy for metastatic cancer?	☐ Yes	☐ No
14. Have you had an allergic or adverse reactions to the medications Versed (midazolam), Propofol, or opioid pain medications?	☐ Yes	☐ No
If yes, what medications?	_____	
What was the reaction you had?	_____	
15. Do you have any of the following:	☐ Yes	☐ No

☐ Implantable Defibrillator ☐ Implantable Pacemaker ☐ Combined Defib/Pacemaker ☐ None

Please give this form to the technician or the doctor during your appointment.

STOP HERE – THE FOLLOWING PAGES NEED TO BE COMPLETED WITH YOUR SURGEON

Lens Choice and Informed Consent for Cataract Surgery

- THIS PORTION SHOULD BE COMPLETED WITH YOUR SURGEON – PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT

Please indicate which lens selection you and your doctor have agreed on. You only need to complete the section that applies to your agreed upon lens choice:

_____ *Initials*

STANDARD LENS FOR *DISTANCE* VISION: I wish to have cataract surgery with a STANDARD lens for **DISTANCE** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*
☐ *With Optiwave Refractive Analysis (ORA)*

_____ *Initials*

TORIC LENS FOR *DISTANCE* VISION: I wish to have cataract surgery with a TORIC lens for **DISTANCE** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

Please rewrite the following sentence: **"I will need glasses for all near and intermediate tasks."**

_____

_____

_____ *Initials*

STANDARD LENS FOR *NEAR* VISION: I wish to have cataract surgery with a STANDARD lens for **NEAR** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*
☐ *With Optiwave Refractive Analysis (ORA)*

_____ *Initials*

TORIC LENS FOR *NEAR* VISION : I wish to have cataract surgery with a TORIC lens for **NEAR** vision on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

Please rewrite the following sentence: **"I will need glasses for all distance and intermediate tasks."**

_____

_____

_____ *Initials*

STANDARD LENS WITH ASTIGMATISM: I have astigmatism and/or a prism in my glasses and wish to have cataract surgery with a STANDARD LENS on my (*check one*)

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

Please rewrite the following sentence: **"I will need to wear glasses for all tasks after cataract surgery."**

_____

_____

_____ *Initials*

PANOPTIX, VIVITY, OR LIGHT ADJUSTABLE LENS (LAL) FOR RANGE OF VISION:
I wish to have a PanOptix, Vivity, OR LAL lens for on my *(check one)*

_____*Surgeon Initials*

☐ *Right Eye* ☐ *Left Eye* ☐ *Both Eyes*

Although this option will give me the most freedom from spectacles, it is possible that even after successful cataract surgery, glasses will be required for some, or all, visual tasks.

Please rewrite the following sentence: **"I may still need glasses for reading or in dim light."**

_____

_____

PATIENT'S ACCEPTANCE OF RISKS:
The main rationale for cataract surgery is to improve the quality of vision. I understand there are no guarantees, and I may still need glasses for all ranges of vision, regardless of my lens choice for surgery.

Initials_____

After meeting with my surgeon: I understand that it is impossible for the doctor to inform me of every possible complication that may occur. In signing below, I acknowledge that I have read the preceding pages and agree that the doctor has answered all my questions to my satisfaction. I understand the risks, benefits, and alternatives complications of cataract surgery, as explained to me by my ophthalmologist, and I have been offered a copy of the consent.

_____	_____	_____
Patient's Name (Printed)	Patient Signature	Date
_____	_____	
Ophthalmologist	Date	