Patient: _____

AUTHORIZATION TO PERFORM SERVICES - Cataract Surgery with an upgrade (per eye)

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	$ 1,100.00	$ 2,050.00	$ 2,550.00	$ 3,400.00	Insurance deductible & copayment fees
Post Refractive Surgery	$ 1,100.00	$ 2,350.00	$ 2,850.00	$ 3,400.00	
Self-Pay/Cosmetic	$ 3,100.00	$ 4,050.00	$ 4,550.00	$ 5,400.00	$ 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: ☐ Toric ☐ Panoptix-Panoptix Toric ☐ Vivity-Vivity Toric ☐ Optiwave Analysis ☐ LAL ☐ LAL+ ☐ BASIC

Surgery Date _____ OS (left eye)
Lens: ☐ 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

If you are receiving any premium service, 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, Cash or Check to COASTAL SURGICAL CENTER..