Date:

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Laser Surgery Information and Informed Consent Package
("Cataract")

Prepared for: ____________________________________

**This packet is being provided to you by Siems Advanced Lasik and Eye Center to assist you in making an informed decision about whether to undergo the surgical procedure for Cataract Removal with Lens Implant, Lensectomy with Lens Implant or Accommodative Intraocular Lens (commonly for treatment of Presbyopia). This surgical procedure will be referred to as "Cataract" in this package.

Please read this material carefully

You are encouraged to discuss and ask questions regarding the information in this packet with your surgeon, optometrist and or counselor.

You have been given information about your condition and the recommended surgical, medical or diagnostic procedures to be used. This consent form provides a written confirmation of such discussions by recording some of the more significant medical information given to you. This is intended to make you better informed so that you may give or withhold your consent for surgery. Take as much time as you wish to make your informed decision about signing this consent. You have the right to ask questions about any procedure/s before agreeing to have the operation.

For you to make the best choices of treatment and get the best possible results we want you to understand your eye condition, treatment options benefits, risks and potential outcomes. If you do not understand something we discuss, if we use medical terminology instead of simple/common terms or if you have more questions, ask us before you sign this form.

I. RISKS / BENEFITS OF PROPOSED PROCEDURE(S):

Patient's Initials

_____ **A.** I understand that just as there may be benefits to the procedure proposed medical and surgical procedures also involve risks. These risks include allergic reactions, bleeding, blood clots, infections and adverse side effects of drugs and even loss of bodily function or life.

_____ **B.** I also realize that there are particular risks associated with cataracts and lens implant surgery. Risks of cataract or lensectomy surgery include but are not limited to: infection (1/1000 or 0.001% of patients), retinal detachment (1/500 or 0.002% of patients), macular edema (1/100 or 1% of patients), corneal edema, bleeding double vision, droopy eyelid, problems with implant including incorrect implant power, poor visual outcome and decrease in best corrected visual acuity.

_____ **C.** If an anesthetic injection is required for surgery, it may cause complications including perforation of the eyeball, dysfunction of the optic nerve and interference with circulation of the retina, drooping eyelid, crossed eye, respiratory depression and low blood pressure. Topical anesthesia is not associated with these potential complications. **An anesthesiologist will be billed for charges and this office is not responsible for these fees.**

_____ **D.** Your surgeon plans to implant an intraocular lens after the cataract is removed. If you are having a lensectomy performed due to your high level of refractive correction, your own lens will be removed and an intraocular lens will be implanted. Occasionally there are circumstances discovered during the surgery which may make it medically unsafe to implant the lens. In these type situations you will need to decide to have another operation at a later time in order to implant the lens if it is medically appropriate to do so.

Continued:

_____ **E.** After lensectomy or cataract surgery, a capsule will form around the vision where the cataract existed. Treatment to break up the capsule is done with a laser treatment called a "Yag Capsulotomy". The treatment is performed in the office and takes only a matter of minutes to perform. Usually one eye is treated at a time. The cash cost for the procedure is $400.00 per eye. If you have insurance a pre-certification / pre-authorization will be called in to your provider. You will be responsible for co-pays, deductibles or out of pocket expenses arising from anything not covered by your insurance.

_____ **F.** For patients experiencing astigmatism prior to lensectomy or cataract surgery, you may need to be post-operatively enhanced with Lasik surgery or glasses. The fee for Lasik surgery is $500.00 per eye. Insurance does not cover the cost of any Lasik procedure.

There are other complications of surgery but it is not possible to warn you of every conceivable risk.

II. Complications, Unforeseen conditions and Results:

I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course other proposed procedures, unforeseen conditions may be revealed requiring the performance of additional procedures and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

III. Ride Agreement

This confirms that I have been informed that I should not, under any circumstances drive following refractive surgery. More specifically I should abstain from driving until my vision has been proven to meet or exceed the minimum vision requirement as specified by Nevada State Department of Motor Vehicles (DMV).

This also confirms that I have been informed that in no event should I attempt to drive myself home immediately following surgery and that I should obtain a driver from my one day post operative visit.

I have read and agree to these terms, conditions and precautions. I fully understand and accept any risks involved by not adhering to the precautions advised within this packet. If I do not cooperate fully with these terms, conditions and precautions, I understand that I am willfully going against the medical advice given to me by Siems Advanced Lasik and Eye Center.

By signing this document I declare that I agree to the terms, conditions and precautions advised to me.

Patient's Signature: ______________________ Date: ____________

Patient Consent and agreed to statement:

I have read this informed consent form (or it has been read to me). The Cataract procedure has been explained to me in terms that I understand. I have been informed about the possible benefits and possible complications, risks and consequences to treat/manage my condition. I understand that it is impossible for my doctor to inform me of every conceivable complication that may occur. I have been given the opportunity to ask questions and have received satisfactory answers to any questions I have asked. I understand that no guarantee of a particular outcome was given and that my vision could become better or worse following treatment.

My Doctor has explained to me that the following conditions exist in my case:

CONDITION:

☐ **Cataract** ☐ **Corneal Problems** ☐ **Glaucoma** ☐ **Diabetic**
☐ **Retinopathy** ☐ **Macular Degeneration** ☐ **Other:** ___________

I give my consent to have the following surgical procedure performed that is listed below. I give Jon Siems, M.D. permission and consent to have him perform my surgical procedure.

I understand that the procedure for evaluating and treating/managing my medical condition are:

☐ **Cataract Removal with lens Implant** ☐ **right eye** ☐ **left eye**
☐ **Lensectomy with lens Implant** ☐ **right eye** ☐ **left eye**
☐ **Accommodative Intraocular Lens** ☐ **right eye** ☐ **left eye**
☐ **Other:** ___________________________________

I authorize the physicians and other health care personnel involved in performing my surgical procedure in providing my pre-operative and post-operative care to share with one another information relating to my health, my vision, or my surgical procedure that they deem relevant to providing me with care.

I have had sufficient time to review this informed consent form. A physician or an associate has adequately addressed my questions and or concerns. By signing below, I am making an informed decision to undergo the surgical procedure to manage my medical condition. I have received a signed copy of this consent for my personal records.

Patient Printed Name: ______________________ Date: ___________

Patient's Signature: ______________________ Date: ___________

Witness Signature: ______________________ Date: ___________

Consultant Signature: ______________________ Date: ___________

Patient – Physician Arbitration Agreement

1. It is understood that any dispute as to medical malpractice that is as to whether any medical services rendered under this agreement were unnecessary, improperly, negligently or incompetently rendered will be determined by submission to an arbitration as provided by Nevada Law and not by a lawsuit or resort to court process except as Nevada Law provides for judicial review of arbitration proceedings. Both parties to this contract are entering into this contract are giving up their constitutional rights to have such a dispute decided in a court of law before a jury and instead are accepting the use of arbitration.
2. I agree to be bound by the rules of the American Arbitration Association.
3. Arbitration of any dispute arising hereunder shall be subject to the provisions of the Medical Injury Compensation Reform Act of 1975 (MICRA). Furthermore, this arbitration agreement shall be binding upon the spouse, all legal heirs and minors including any unborn child or children of the patient.
4. **NOTICE:** BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL OR COURT TRIAL. SEE ARTICLE 1 OF THIS AGREEMENT.

Patient Printed Name: ______________________ Date: __________

Patient's Signature: ______________________ Date: __________

Physician's Agreement to Arbitrate:

I likewise agree to be bound by the rules of the American Arbitration Association.

Physician or Duly-Authorized Representative Printed Name: James Siems

Physician or Duly-Authorized Representative Signature: ______________________

Date: __________

The exact wording of the first and fourth paragraphs outlined is required by the Nevada Code of Civil Procedure, Section 1295.

Confirmation of Co-Management Selection by Patient

To ensure you receive the best surgical results, a team of doctors will be working together to provide you with the highest quality of care, before, during and after your surgery. A complete eye examination will be provided to you by **Dr. Amel Youssef**, a licensed Optometrist. Following surgery a number of post-operative visits will be necessary. The first visit will be provided by **Dr. Jon Siems** and the following visits will be provided by **Dr. Amel Youssef** or **Dr. Jon Siems**.

After attending college and medical school, an Ophthalmologist is then trained for three (3) or more years in surgery and diseases of the eye. An Optometrist attends Optometry school after completing college and receives four (4) years of specialized training in diagnosing and treating refractive conditions and diseases of the eye including pre and post-operative care. Your Ophthalmologist and Optometrist have each been licensed by the State of Nevada. The practice of the Ophthalmology and Optometry are, respectively, regulated by the following board of examiners:

Nevada State Board of Medical Examiners
PO Box 7238
Reno, NV 89510
775.688.2559

Nevada State Board of Optometry
PO Box 1824
Carson City, NV 89702
775.883.8362

I knowingly and willingly desire **Dr. Amel Youssef**, a licensed Optometrist to perform my pre-operative exam and my post-operative care following my eye surgery. Should the need arise; I understand that I may request to see **Dr. Siems** anytime. I also understand that prescribed medication schedules after the surgery.

Patient Printed Name: ______________________ Date: __________

Patient's Signature: ______________________ Date: __________

Witness Signature: ______________________ Date: __________

Optometrist Signature: ______________________ Date: __________

Payment and Cancellation Policy for surgical procedures:

** Siems Advanced Lasik and Eye Center requires payment one week prior to surgery to ensure payment for the medical procedure/services being rendered. Should you need to cancel a surgical procedure all together due to any reason other than anything arising from unknown or unexpected medical complications after being examined by an Optometrist or Ophthalmologist, there will be a cancellation fee of $150. In order to avoid the $150 cancellation fee we must receive notice within 24 hours of your scheduled surgery. There is no fee to reschedule an appointment.

Patient's Signature: ______________________ Date: __________

PATIENT NAME: ______________________________

CHIEF COMPLAINT: ☐ Blurred Vision ☐ Glare problems ☐ __________
☐ Complaint interferes with patient's ability to do activities of daily living.

MEDICAL HISTORY: ☐ No medical history to contraindicate planned ophthalmic surgery.
☐ Other____________________

HISTORY OF PREVIOUS EYE SURGERY: ☐None ☐Right Eye ☐Left Eye
☐CAT/IOL ☐Other: __________

SOCIAL/ FAMILY HISTORY: ☐ No significant history impacting planned surgery
☐ Other____________________

ALLERGIES: ☐ NKA ☐ ____________________

PHYSICAL EXAM: ☐ No physical findings to contraindicate ophthalmic surgery with the planned anesthesia, unless exception/significant finding is indicated below.

☐ Respiratory __________ ☐ Neuro __________
☐ Cardiac __________ ☐ Extremities __________
☐ GI/GU __________

Planned Anesthesia: ☐ Anesthesiologist ☐ IVCS-RN **ASA Score:** 1 2 3 4

PRE-OPERATIVE DIAGNOSIS: ☐ Cataract, Senile ☐ Cataract, Juvenile ☐ Cataract, __________
☐ Nuclear ☐ Anterior Subcapsular ☐ Posterior Subcapsular
☐ Cortical ☐ Other __________
☐ OTHER: __________

PLANNED PROCEDURE: **Scheduled date:** __________ ☐ Right eye ☐ Left eye
☐ Cataract extraction w/ or w/o IOL implant ☐ ICL
☐ __________ ☐ IOL Insertion/Exchange

DISCHARGE NOTES: Complication: ☐ None ☐ Other:__________
____
____

Condition Stable: Discharge to Home ☐

I have discussed with my patient the surgical or invasive procedure to be performed along with the benefits and risks of the procedure and alternative options. Informed consent was discussed with the patient, including the risks, benefits, potential complications, and any alternative options associated with the planned procedure and anesthesia.

PHYSICIAN'S SIGNATURE: ____________________ **Date:** __________