**A picture containing font, graphics, typography, logo

Description automatically generatedA picture containing font, graphics, typography, logo

Description automatically generated**

|  |
| --- |
| SightCraft Eyecare and Custom Optical540 Northwood RdWest Palm Beach, FL 33407Phone 561-931-4114| Fax 561-931-4130[info@sightcrafteye.com](mailto:info@sightcrafteye.com) www.sightcrafteye.com |

**Consent for planned co-management after eye surgery**

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of surgeon) will be performing

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type of surgery) on me. Due to continuity of care, I would like Dr. Sara Berke to perform my postoperative follow-up care. I have discussed this postoperative selection with my surgeon.

I understand that my co-managing optometrist Dr. Sara Berke will contact my surgeon immediately if I experience any complications related to my eye surgery.

I understand that my financial responsibility will be in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_ and is due to Dr. Sara Berke at the time of service.

I understand that I may contact Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of surgeon) at any time after the surgery.

Patient (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (Sign):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_