



Supplemental Informed Consent – Astigmatism Correction with Toric IOL

In some individuals, the cornea is not perfectly round causing astigmatism. Traditional intraocular lens implants do not correct astigmatism. To correct astigmatism during cataract surgery an astigmatism correcting intraocular lens called a “Toric IOL” must be used.

If you decide to have surgery to correct astigmatism using the Toric IOL, then extensive measurements of the eye will be required. As with any measurement, there is a high, but variable degree of accuracy. Due to measurement and individual healing variability, there is no guarantee as to achieving the desired refractive (glasses prescription) goal.

PATIENT RESPONSIBILITY FOR COSTS - \$1,500.00 per eye

I understand that I am responsible for the additional costs of surgery using a toric intraocular lens. Medicare (and any secondary coverage) reimburses the removal of the cataract but stipulates that the extra expenses associated with the use of advanced implants are billable directly to the patient and are not covered benefits.

_____ (Initial here)

I understand that the fee for the lens implant must be paid in full to Swedberg Eye Care prior to insertion of the lens implant

_____ (Initial here)

PATIENT’S STATEMENT OF ACCEPTANCE AND UNDERSTANDING

I understand that I am making a decision for myself, such that I feel the potential benefits of this procedure outweigh the potential risks. I understand that despite all reasonable efforts there is a chance that I may still need to wear glasses and/ or contact lenses after surgery for all activities. I have had ample time to read this document and ask questions. My ophthalmologist their associated staff have answered all questions to my satisfaction. I, therefore, consent to undergoing cataract surgery with a toric IOL. I have been fully informed of my right to receive a copy of this signed and dated consent form.

Patient Name _____ Signature _____

Witness Signature _____

Surgeon Signature _____

Date of Signature _____



Supplemental Consent - Presbyopic Reduction Surgery using PanOptix Multifocal IOL

Advanced multifocal IOL designs allow for a patient to elect a correction that improves both far and near vision. The PanOptix IOL is capable of providing an improved range of vision without glasses. I understand that there are inherent differences between a multifocal lens and standard monofocal lens implants. While the majority of patients are satisfied with the results of having multifocal IOLs, a higher incidence in visual disturbances were reported with multifocal lens when compared with traditional monofocal (standard) lenses in clinical trials. I also understand events during surgery may make it impossible to implant the PanOptix lens. I will leave this decision to the surgeon's discretion

PATIENT RESPONSIBILITY FOR COSTS - \$2,500.00 per eye

I understand that I am responsible for the additional costs of the surgery using the PanOptix lens. Medicare (and any secondary coverage) reimburses the removal of the cataract but stipulates that the extra expenses associated with the use of advanced implant are billable directly to the patient and are not covered benefits.

_____ (Initial here)

I understand that the fee for the lens implant must be paid in full to Swedberg Eye Care prior to insertion of the lens implant

_____ (Initial here)

PATIENT'S STATEMENT OF ACCEPTANCE AND UNDERSTANDING

I understand that I am making a decision for myself, such that I feel the potential benefits of this procedure outweigh the potential risks. I understand that the implantation of the advanced multifocal IOL is designed to decrease my dependency on eyeglasses and/ or contact lens but I still may need to wear glasses and/ or contact lens after my surgery. I have had ample time to read this document and ask questions. My ophthalmologist and his associates have answered all of my questions to my satisfaction. I, therefore, consent to undergoing cataract surgery with this special lens implant. I have been fully informed of my right to receive a copy of this signed and dated consent form.

Patient Name _____ Patient Signature _____

Witness Signature _____

Surgeon Signature _____

Date of Signature _____