CLARITI
ADVANCED VISION CORRECTION

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Consent for Postoperative Care

Patient Name: _____ ID # _____
Procedure: _____ Date: _____
Surgeon: _____
Optometrist: _____Pre ____ Post ____

___ No comanagement fees ___ Comanagement fee of $_____

Post operative care is any visit related to your eye surgery for one year. Follow up after surgery is important in maintaining healthy eyes. As a patient of Dr. Matthew Fornefeld, you have the right to elect post operative care with your local optometrist. You may also elect to have Dr. Fornefeld care for your postoperative needs.

_____ I elect to have Dr. Matthew Fornefeld provide my post operative care at Clariti.

_____ I elect to have Dr. _____, my local optometrist, provide my post operative care. I authorize Clariti to share my medical records with my optometrist, listed above. I may return to Clariti at any time for post operative care. The fees I have paid for my surgery will be shared with my optometrist. Clariti is not responsible for any additional fees that my optometrist may charge at any time for post operative care.
Date of release of care: _____

Patient Signature:_____ Date: _____

Witness Signature: _____ Date: _____