

Can be completed by Co-Managing PEPC or Surgery Center—Please keep in Patient File

CO-MANAGEMENT CONSENT

Patient Name: _____

Dr. _____ will be performing _____ on me.
(Name of surgery)

It is my desire to have my primary optometrist/ophthalmologist, Dr. _____
(Name of PECP)
perform my preoperative and/or postoperative care.

I understand that a record of findings will be sent to my surgeon following each visit with my
Primary eye care provider and that my surgeon will be informed if I experience any complications
related to my eye surgery. I understand that I may also contact my surgeon at any time after the
surgery.

I understand that there are no additional fees associated with co-management and that North
Cascade Eye Associates will collect outstanding fees, if any, above those individually billed to
Insurance and forward the appropriate co-management fee to Dr. _____
(Name of PECP)
for postoperative care.

DATE: _____

SIGNATURE: _____

WITNESS: _____