Hollingshead Eye Center
360 East Mallard Dr., Suite 125
Boise, ID 83706
208-336-8700
208-336-6463 (fax)

CONFIRMATION OF POSTOPERATIVE COMANAGEMENT SELECTION BY THE PATIENT

Patient: _____

Patient Confirmation

It is my request to have my own optometrist, _____, perform my postoperative follow-up care after my ☐ cataract ☐ refractive ☐ YAG Laser surgery. I have discussed the postoperative selection with my ophthalmologist, Dr. Mark Hollingshead. Dr. Hollingshead has informed me that an optometrist may lawfully provide postoperative care under Idaho state law.

I have been informed that I may receive additional statements and explanations of benefits from my insurance because two physicians are providing care. My payment obligations to the optometrist shall be determined by my insurance coverage.

My optometrist will share post-operative information with Dr. Hollingshead and will contact him immediately if I experience any complications related to my eye surgery. I understand that I will only be co-managed when my surgeon deems it appropriate, and I may contact Dr. Hollingshead's office at any time after the surgery.

All questions have been answered to my satisfaction.

Procedure: _____ Eye(s) _____ Date of Surgery: _____

Patient Signature: _____Date: _____