

EXPLANATION OF BENEFITS, RISKS, AND OPTIONS

The following items have been discussed with the patient/responsible party prior to all operations:

GENERAL INFORMATION:

- _____ Description of alternative operative procedures
- _____ Preferred technique and why
- _____ Available methods of anesthesia/sedation and discussion of surgeon's preferences
- _____ Postoperative recovery time and limitation of normal activities
- _____ Long term limitations on individual lifestyles, if any

ANTICIPATED OUTCOME:

- _____ Anticipated aesthetics
- _____ Constraints of individual's anatomy
- _____ If asymmetry exists, complete correction unlikely
- _____ Location and probable nature of scar(s)

INHERENT RISKS:

- _____ Inherent risk assumed by patient as part of procedure
- _____ Standard anesthesia risks

COMPLICATIONS:

- _____ Infection
- _____ Bleeding requiring return to O.R.
- _____ Hematoma
- _____ Excess or obvious scar
- _____ Chronic pain
- _____ Weakness or paralysis of the muscles that elevate the brow or close the eye or face
- _____ Asymmetry of the eyebrows or eyelids (often present early postoperatively)
- _____ Possible diminished or absent sensation to the forehead or cheek
- _____ Double vision
- _____ Visual loss
- _____ Lumps/irregularities under or on the skin
- _____ Skin loss requiring further reconstructive surgery
- _____ Irritation or dryness of the eyes
- _____ Skin color or pigmentation change
- _____ Tearing
- _____ General disappointment

ECONOMICS:

- _____ Costs of procedure(s)
- _____ Responsibilities for possible later revisions or complications

Alternative methods of treatment, if any, have been explained to me, as have been the benefits and risks of each. We have also discussed the disadvantages, if any, of not having the operation or procedure. I am advised that though good results are expected, complications cannot be anticipated and that therefore there can be no guarantee, either expressed or implied, as to the results of the surgery or cure. I understand there is a remote risk of death or serious disability with any surgical procedure. The doctor has answered all my questions.

The doctor has explained to me the most *likely* complications or problems that might occur in this operation and during the healing period, *and I understand them*. The doctor has offered to detail the less likely complications which, even if rare, could occur. Please check one:

_____ *I do wish to have these described to me* _____ *I do not wish to have these described to me*

I certify that I have read and understand all the above and that all blank spaces were checked or filled in prior to my signature.

Patient or Legal Guardian/Representative Signature

Date

I hereby certify that I, or a member of my staff have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understand what I have explained and answered.

Signature of Doctor

Date

Note: This document must be made part of the patient's medical records.

LETTER OF UNDERSTANDING

This Letter of Understanding is intended to provide you the necessary information on preparation for payment of fees associated with Elective/Cosmetic surgery.

____ Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a)(1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny or reduce payment for that service. I believe, in your case, Medicare **will deny** payment for the above listed procedures for the following reason: **That the cosmetic procedures that you have elected to have are not covered by Medicare.**

____ Your insurance company will only pay for services that it determines to be "reasonable and necessary". If your insurance company determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under their program standards, then your insurance company will deny or reduce payment for that service. I believe, in your case, that your insurance company **will deny** payment for the above listed procedures for the following reason: **That the cosmetic procedures that you have elected to have as listed above are not covered by your plan.**

Please be informed that the cosmetic surgical procedures that your doctor has recommended may result in three separate fees. Listed below are brief explanations of each fee and an **approximation of the amounts based upon estimated surgery time.**

1. **Surgeon Fee \$ _____** This fee represents the surgeons portion of your bill and is paid directly to the doctor's office at the time the surgery is scheduled. **Payment in full must be received seven (7) days prior to the surgery date.**

2. **Facility Fee \$ _____** This fee represents the hospital portion of your bill. The fee is dependent on actual time spent in the operating room. If your time runs over the original calculation you will be billed for the balance due for the elective surgery.

3. **Anesthesia Fee \$ _____** This fee represents the anesthesiologist portion of your bill. The fee is dependent on actual time spent in the operating room and type of anesthesia required. If your time runs over the original calculation you will be billed for the balance due for the elective surgery.

4. **TOTAL DUE: _____**

PLEASE MAKE CHECK PAYABLE TO OCULOPLASTIC SURGERY, INC. FOR THE TOTAL DUE THE SURGEON. IF YOU ARE HAVING FUNCTIONAL SURGICAL PROCEDURES IN ADDITION TO ELECTIVE PROCEDURES YOU MAY BE BILLED FOR CO-PAYS AND/OR DEDUCTIBLES THAT ARE RELATED TO THE FUNCTIONAL PORTION OF THE SURGERY.

I have read and understand my obligation concerning the fees associated with having surgery at the facility recommended by my physician or directed by my insurance company.

____ *I certify that I have read and that I understand this consent and that all blanks were filled in prior to my signature.*

Patient or Legal Guardian/Representative Signature

Date