

At LASIK MD, we strongly believe that you should have all of the necessary information on-hand in order to make an informed decision about your procedure. The content of this consent form is not intended to alarm you. Please note that serious complications are extremely rare and that the vast majority of our patients are satisfied with the results of their procedure.

1. I understand that I am a candidate for **LASIK (LASER IN SITU KERATOMILEUSIS) SURGERY**, a form of laser surgery where a surgeon will anesthetize my eye with a topical anesthetic, create a flap from my cornea using a specialized instrument (a microkeratome or a femtosecond laser), and use an excimer laser to reshape the cornea.

Patient initial for LASIK: _____

OR

2. I understand that I am a candidate for **PRK (PHOTOREFRACTIVE KERATECTOMY) SURGERY**, a form of outpatient surgery in which a surgeon uses a specialized instrument to remove the surface epithelial cells of the cornea as well as a device called an excimer laser to reshape the cornea. A compound called Mitomycin-C (MMC) may be used in patients undergoing PRK. Mitomycin-C is known to modulate wound healing and significantly reduce the occurrence of aggressive healing of the cornea after PRK, which in certain cases can lead to haze and scarring. Clinical studies and our own results have shown MMC to be safe in the short term and intermediate term after PRK surgery (follow up for 7 years) with no vision threatening complications known to be related to MMC reported to date. I understand that the long term (greater than 7 years) safety of Mitomycin use during PRK is unknown.

Patient initial for PRK: _____

LASIK or PRK, the identified surgery, is referred to as the "Procedure" in the following:

3. I understand the Procedure will be performed by Dr. _____, M.D.. ("my surgeon") at LASIK MD.

on this _____ day of _____.

(i) both eyes [INITIAL] _____; OR

(ii) on _____ (DATE) my right eye [INITIAL] _____

and on _____ (DATE) my left eye [INITIAL] _____ .

4. I have reviewed and carefully read the Lasik Information Booklet for **LASIK** surgery and for **PRK**. This information was mailed to me or given to me by my eye care professional prior to my pre-operative appointment. I acknowledge that I have had ample time and opportunity to review and understand this information at my leisure. I have also discussed the Procedure that I am to receive with eye care professionals and doctors at the Centre.
5. The nature of the Procedure, the possible complications and risks, as well as the possible benefits of the Procedure, the alternatives to the Procedure and the risks and benefits of those alternatives have been explained to me in language and using terminology that I understand. The Centre's eye care professionals and doctors have answered all of my outstanding questions about the Procedure.
6. I understand that this Procedure is an elective surgical procedure, and that there is no emergency or medical condition which requires me to have the Procedure.
7. Neither my surgeon, nor my optometrist, nor the Centre staff has made any promises or warranties or guarantees as to the success or effectiveness of the Procedure. I have been advised that after the Procedure, my vision may not be as clear and sharp as it was with glasses or contact lenses before the Procedure.
8. I understand that the Procedure may not eliminate the need for corrective lenses for all activities and that after the Procedure, I may need glasses or contact lenses for reading, driving or certain other activities, even if I did not wear them before. I also understand that the Procedure can unmask the need for reading glasses, and that I may have to use them after the Procedure, even if I did not wear them before.
9. I understand that after the Procedure I may experience side effects such as pain, discomfort and scratchiness, halos, blurred vision or fluctuations in vision, which may be temporary or could be permanent. I have been advised that I may find some of these side effects difficult to tolerate.
10. I understand that there are numerous risks and complications, both known and unknown connected with the Procedure, including but not limited to infections, hemorrhage, delayed healing, under or over correction, and other risks and complications that could affect my vision and my general health on a temporary or permanent basis, and could require additional surgery, including, but not limited to, enhancement or a cornea transplant. Those risks also include, but are not limited to, partial or total blindness, loss of a cornea, retinal damage or loss of an eye.

11. I understand that the longer term effects of the Procedure (performed in Canada since 1990 and shown to be effective for up to 19 years) are not known.
12. I understand that the Procedure does not correct certain vision problems, including but not limited to amblyopia, strabismus, presbyopia and cataracts.
13. I understand that the field of refractive surgery is continuing to evolve and that if I were to postpone my surgery there is the possibility that the LASIK and/or PRK procedure might be improved or some other procedures might become available.
14. I understand that my surgeon is an ophthalmologist (a medical doctor specialized in eye surgery) who is licensed to practice ophthalmology in the State of New York. My surgeon is also experienced in both LASIK and PRK techniques.
15. I understand that I will need certain post-operative care. Post-operative care (24 hour, 1-2 week, one month, and any additional post-op visits that are deemed necessary by my eye care specialist) at the Centre (except for the cost of glasses, punctal plugs, contact lenses or the cost of certain medications) is included in my fee.
16. I understand that if I so desire, I may make other arrangements for post-operative care at my own expense. LASIK MD, the clinical staff, and my surgeon can only provide me (if I choose) with a list of doctors in my area who would be willing to see me post-operatively. They cannot make recommendations or provide information about the competency or quality of medical care of these independent practitioners. If I choose to have my post-operative care elsewhere than the Centre, I confirm that the responsibility of arranging that care is my own and not that of the Centre, nor my surgeon. I also confirm that I become responsible for the quality, outcome and consequences of that post-operative care, and indemnify LASIK MD and my surgeon of any consequences that result directly or indirectly from post-operative care performed elsewhere and not performed at the Centre.
17. Understanding the above, I choose to have my post-operative care elsewhere than the Centre. I confirm that I have made arrangements to have my post-operative care provided by _____, M.D., or OD, who is an optometrist/ophthalmologist (circle one) located in _____ and who has agreed to provide my post-operative care. (Patient may delete this clause if choose to have post-operative care at the Centre).

18. I have had the opportunity to ask questions about the Procedure and all of my questions have been answered satisfactorily.

19. I give my surgeon, my optometrist, LASIK MD and the Centre permission to use data about my treatment for research purposes. I understand that my name and personal identifying information will remain confidential, unless I give written permission for the disclosure of such information. (Patient may delete this clause if choose not to participate in research activities).

20. I give my surgeon and LASIK MD permission to videotape or photograph the Procedure. (Patient may decline to be video taped and may delete this clause).

21. I understand that the applicable governing law for this procedure is the law of the State of New York.

22. I am not under the influence of any sedative. I am of clear mind and understand the nature of the Procedure and the possible risks related to the Procedure.

I understand that by signing below, I am indicating that I have read and understood the information in this Patient Consent Form, that I have read and understood the information in the Lasik Information Booklet, that I have been verbally advised about the Procedure, that I have had an opportunity to ask questions, that I have received all of the information I desire concerning the Procedure, and that I authorize and consent to the performance of the Procedure and any different or further procedures which in the opinion of my surgeon are necessary due to an emergency.

Patient's Name (please print): _____

Patient's Signature: _____

Surgeon's (Witness) Name (please print): _____

Surgeon's (Witness) Signature: _____

Date: _____ Time: _____

Patient Address: _____

Patient Telephone Number (Day): _____

Patient Telephone Number (Evening): _____

Date of Birth: _____

LASIK MD
GOVERNING LAW

The patient agrees that the relationship between himself/herself and the performing surgeon at LASIK MD shall be governed and construed in accordance with the laws of the State of New York.

JURISDICTION

The patient acknowledges that the treatment and services were performed in State of New York and that the Courts of the State of New York shall have jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. The patient consents to jurisdiction in the Courts of the State of New York, even though the Courts in their own nation, state or province may provide additional rights, remedies or damages not available in the Courts of the State of New York. The patient hereby agrees that he/she will commence any such legal proceeding in the State of New York and only in the State of New York and hereby submits to the jurisdiction of the Courts of the State of New York.

Patient's Name (printed): _____

Patient's Signature: _____

Date: _____ Time: _____ Place (city): _____

Witness's Name (printed): _____

Witness's Signature: _____