PATIENT CONSENT FORM

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 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:
   i. a microkeratome [INITIAL] _____
   ii. a femtosecond laser [INITIAL] _____
   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 laser surgery in which a surgeon uses a specialized instrument to remove the surface epithelial cells of the cornea as well as an excimer laser to reshape the cornea. A compound called Mitomycin-C (MMC) may be used in patients undergoing PRK. MMC 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. Occasionally the degree of pain following PRK surgery can be significant, topical anesthetic drops and narcotic medications will be required to assist in pain management.

Patient initial for PRK: _____

OR

3. I understand that I am a candidate for **LASIK ENHANCEMENT BY RELIFT**, a form of laser surgery where a surgeon uses specialized tools to lift the original flap that was created during the primary LASIK surgery. The surgeon then uses an excimer laser to reshape the cornea.

Patient initial for LASIK ENHANCEMENT BY RELIFT: _____

OR

4. I understand that I am a candidate for **LASIK ENHANCEMENT BY RECUT**, a form of laser surgery where a surgeon uses a specialized instrument to create a corneal flap. The surgeon then uses an excimer laser to reshape the cornea.

Patient initial for LASIK ENHANCEMENT BY RECUT: _____

LASIK, **PRK**, **LASIK ENHANCEMENT BY RELIFT**, or **LASIK ENHANCEMENT BY RECUT**, the identified surgery, is referred to as the "Procedure" in the following:

1. I understand the Procedure will be performed by _____, M.D. ("my surgeon") at a LASIK MD centre (hereinafter referred to as the "Centre"),

on this _____ day of _____;

(i) both eyes [INITIAL] _____; OR

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

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

2. 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

3. 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. I have had the opportunity to ask questions about the Procedure and any concerns I may have. The Centre's eye care professionals and doctors have satisfactorily answered all of my outstanding questions and addressed any concerns I may have about the Procedure.

4. 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.

5. Neither my surgeon, nor my optometrist or other eye care professional, 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.

6. 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.

7. 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.

8. I understand that there are numerous risks and complications, both known and unknown, connected with the Procedure, including but not limited to infections, delayed healing, under or over correction, regression 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, in very rare cases, a cornea transplant. These risks may also result in prolonged visual recovery, leading to delays in resuming work. These risks also include, but are not limited to, partial or total blindness, loss of a cornea, retinal damage or loss of an eye.

9. I understand and agree that an enhancement procedure by the excimer laser may be required. I understand that if required, the procedure for any enhancement will be the procedure best determined by my surgeon, and that such procedure may differ from the initial Procedure.

10. I understand that the longer term effects of laser vision correction, performed in Canada since 1990 and shown to be effective for up to 20 years, are not known.

11. I understand that the Procedure does not correct certain vision problems, including but not limited to amblyopia, strabismus, presbyopia and cataracts.

12. I understand that my surgeon is an ophthalmologist (a medical doctor specialized in eye surgery) who is licensed to practice ophthalmology in the Province/State where I am having my Procedure. My surgeon is also experienced in both LASIK and PRK techniques.

13. I understand that I will need certain post-operative care. Post-operative care (24 hours, 1-2 week, one month and one year, as well as 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 (comfort plugs), contact lenses or the cost of certain medications) is included in my fee.

14. I understand that LASIK MD strongly recommends that I pursue biennial Ocular Health Exams with an optometrist at my own expense. LASIK MD, the clinical staff, and my surgeon can provide me (if I choose) with a list of doctors in my area who would be willing to see me post-operatively.

15. I understand that LASIK MD cannot make recommendations or provide information about the competency or quality of medical care of these independent practitioners. If I choose to pursue Ocular Health Exams, or require any post-operative care, at an independent practitioner's office, 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 care, and I will indemnify LASIK MD and my surgeon of any consequences that result directly or indirectly from care performed elsewhere than at the Centre.

16. I understand the terms of paragraph 15 above and I will complete Post-operative Exams and/or Ocular Health Exams at an independent practitioner's office in lieu of returning to LASIK MD for Post-operative Exams and/or biennial Corneal Health Exams. I confirm that I have made arrangements to have my Ocular Health Exams provided by _____, M.D., or OD, who is an ophthalmologist/optometrist (circle one) located in _____ and who has agreed to provide my care. (Patient may delete this clause if he/she chooses not to pursue Post-Operative Exams and/or Ocular Health Exams at an independent practitioner's office).

17. I understand that the Procedure I am about to undergo will not protect me against ocular infections, inflammations, disorders or diseases in the future. These conditions can develop at any time and are not related to my Procedure. They include, but are not limited to, conjunctivitis (pink eye), corneal ulcer, stye, eyelid inflammation, vitreous detachment (flashes and floaters)and retinal detachments. The treatment of these emergencies can be provided at any independent practitioner's office. I acknowledge that LASIK MD is not a general ophthalmology clinic, and that the responsibility of arranging the care with an independent practitioner in case of an ocular emergency is my own.

□ I confirm that I have an independent eye care practitioner (e.g. Optometrist) that I can refer to in case of ocular emergencies.

□ I do not have an Eye Care practitioner . I understand that I will have to consult an independent eye care practitioner for any ocular emergencies I may need care for in the future.

18. I give my surgeon, my optometrist, LASIK MD and the Centre permission to use data about my treatment for research/publication 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 he/she chooses not to participate in research/publication activities).

19. I understand that the applicable governing law for this Procedure is the law of the Province/State of _____, being the Province/State where I am having my Procedure, and I agree that the courts of said Province/State will have exclusive jurisdiction to hear and adjudicate any claim which I may have in connection with the Procedure.

20. 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:_____

The Governing Law Agreement attached hereafter must be signed only by U.S. residents having their procedure in Canada

LASIK MD

GOVERNING LAW

The patient agrees that all aspect of the relationship between himself/herself and the performing surgeon, LASIK MD INC. and its affiliates and subsidiaries as well as their employees, agents and representatives (the "Healthcare Providers") shall be governed and construed in accordance with the laws of the Province of _____, Canada.

JURISDICTION

The patient acknowledges that the treatment and services were performed in the Province of _____, Canada, and that the Courts of the Province of _____ shall have exclusive jurisdiction to hear and adjudicate any complaint, demand, claim or cause of action whatsoever, whether based on alleged breach of contract or alleged negligence arising out of the treatment or any aspect of the patient's relationship with the Healthcare Providers. The patient consents to the exclusive jurisdiction of the Courts of the Province of _____, Canada, even though the Courts in his/her own nation, state or province may provide additional rights, remedies or damages not available in the Courts of the Province of _____, Canada. The patient hereby agrees that he/she will commence any legal proceeding which he/she may have in connection to his/her relationship with the Healthcare Providers exclusively in the Province of _____, Canada.

Patient's Name (printed):_____

Patient's Signature:_____

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

Witness's Name (printed):_____

Witness's Signature:_____