BERGEN-PASSAIC CATARACT SURGERY & LASER CENTER, INC

CONSENT FOR SURGERY

Name of Patient _____

Name of Surgeon (s)_____

Your surgeon(s) has recommended the following outpatient surgical procedure(s) ☐ Right ☐ Left

_____

_____

☐ Femto Second Laser ☐ ORA System ☐ _____

This consent is given by you to Bergen-Passaic Cataract Surgery & Laser Center, Inc. (the "Facility").

This outpatient surgical procedure involves risks of unsuccessful results, complications, injury or even death, from both known and unforeseen causes and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature of the surgical procedure, the expected benefits or effects of such surgical procedure, and the available alternative methods of treatment, including but not limited to non-treatment and their risks and benefits. You have the right to be informed of the likelihood of success, any problem(s) associated with recuperation and the possible result of non-treatment. By signing below, you certify and acknowledge that your surgeon has fully explained the surgical procedure(s) with you and that you have evaluated the nature of the procedure(s), any risks, and the availability of alternatives. You further certify that you have asked the surgeon any questions you may have concerning the surgical procedure(s).

You have the right to be informed whether your surgeon has any independent medical research or economic interests related to the performance of the proposed surgical procedure; if the Facility or its staff have any business relationship between individuals treating you or with any educational institutions involved in your care; of any professional relationship to another healthcare provider or institution that may suggest a conflict of interest. Some surgeons have varying degrees of financial interest in the Facility and, in such case you have been offered an alternate site for the procedure.

Dr _____ ☐ does have ☐ does not have a financial interest in the Facility.

Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance. Upon your authorization and consent indicated by your signature below, the above named surgical procedure, together with any different or further procedures which in the opinion of the surgeon may be indicated due to any emergency, will be performed on you as well as the administration of the necessary pre-operative and post-operative medications.

By your signature below, you authorize the disposal of any tissues, members, organs or other matter of any description that are removed surgically.

The surgical procedure(s) will be performed by the surgeon named above (or in the event that the surgeon is unable to perform or complete the procedure, a qualified substitute surgeon chosen by your surgeon), together with associates and assistants, including anesthesiologists, from the medical staff of the Facility to whom the supervising physician or surgeon may assign designated responsibilities.

The person(s) in attendance for the purpose of performing the surgical procedure(s), administration of anesthesia and other medical services are not agents, servants, or employees of the Facility.

By signing below, you agree that: (1) you have read and understood the information provided in this consent; (2) that the surgical procedure(s) set forth above has been adequately explained to you by your surgeon; (3) that you have had a chance to ask questions; (4) that you have received all of the information you desire concerning the surgical procedure; and (5) that you authorize and consent to the performance of the surgical procedure(s), and the provision of supporting medical services as deemed necessary by your surgeon, including but not limited to the administration of anesthetic, pre and post operative therapy, radiology services, and pathology services.

By signing below, you further understand and agree that unless given written instruction to the contrary: (1) following your outpatient surgical procedure you will not drive yourself home or use public transportation; and (2) because your mental alertness may be impaired for several hours following the administration of medication or anesthesia, you agree not to make any decisions or participate in any activities that depend on full mental alertness during that time in accordance with your surgeon's directions; and (3) that admission to a hospital might be necessary and that you agree if your surgeon and/or anesthesiologist decides it is necessary to be admitted to

_____ Hospital.

I consent to and authorize the surgical procedure(s) and other services as set forth above. I have fully discussed the surgical procedure(s) with my surgeon and I have evaluated the nature of the procedure(s), any risks, and the availability of alternative options. I have not withheld any information from my surgeon or the Facility. Finally, I certify that at this time, I am not pregnant.

Signature of Patient/Guardian	Date
Printed Name of Patient/Guardian	If signed by other than patient, indicate relationship
Witness to Signature	Date

Surgeon Certification

I certify that the benefits, risks, drawbacks, complications, side effects, and alternative choices of and to the procedure(s) have been fully explained to the patient and/or the patient's legal guardian. I further certify that I have provided sufficient information to the patient and/or the patient's legal guardian to permit the patient or the legal guardian to give informed consent to the surgical procedure(s) listed above. I further certify that I have fully advised the patient of any financial interest that I may have in the Facility and that I have also informed the patient of alternative locations at which the surgical procedure(s) may be performed.

Signature of Surgeon	Date