Cataract

PATIENT INFO PACKET

middle tn eye

Alissa Hudson, MD

Patient Info

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Alissa Hudson, MD

PATIENT INFO:

Last Name: _____ First Name: _____ MI: ___ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: ○ if same as above

Address: _____ City: _____ State: _____ Zip: _____

Phone #: (____) _____-_____ Cell #: (____) _____-_____ ○ allow text appointment reminders

Email Address: _____ ○ allow email appointment reminders

SSN: _____ DOB: ___ /___ /_____ Age: _____ Sex: ○ Female ○ Male

Employer/School: _____ Occupation: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Spouse Name: _____ Emergency Contact: _____

Relationship: _____ Phone #: (____) _____-_____

INSURANCE INFORMATION:

Primary Insurance: _____ if patient is not primary card holder the following is needed

Policy Holder's Name: _____ SSN: _____ DOB: ___ /___ /_____

Secondary Insurance: _____ if patient is not primary card holder the following is needed

Policy Holder's Name: _____ SSN: _____ DOB: ___ /___ /_____

Do you have a Living Will?: ○ Yes ○ No

Insurance: (Please see back of Registration form for more DETAILS) You agree to pay any portion of the charges not covered by insurance. **If your Insurance Company requires a referral and/or preauthorization, you are responsible for obtaining it.** Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company. A copy of any new insurance cards must be given at the beginning of that visit.

Required Payments at Time of Service: Any co-payments, co-insurance, deductibles and other services that are not covered by insurance. **CHECKS written will be deposited promptly.**

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I _____ **(please print name)** have fully read and understand the HIPAA Compliance and the Financial Policy of Middle Tennessee Eye Associates of Cookeville. I hereby request any benefits on my behalf be paid to the physician(s). I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physician(s) to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician and physician's associates and I consent to receive such care by these providers. I understand that these services are voluntary and I have the right to refuse these services.

I also request that payment of authorized Primary, Secondary, Tertiary, or Medigap (Medicare supplement) insurance benefits be made on my behalf to the provider(s) for any services furnished to me by that provider(s). I authorize any holder of medical information about me to release pertinent information to Primary, Secondary, Tertiary, or Medigap insurances to determine these benefits payable for related services.

Patient Signature: _____ Date: _____

MTEA Associate: _____ Date: _____

IOL Option

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Choose 1 IOL Option below:

○ MONOFOCAL IOL/GLASSES OPTION

I wish to have a cataract operation with a monofocal IOL on my ○ **Right Eye** ○ **Left Eye** and wear glasses for ○ **Near Vision** ○ **Distance Vision**

○ MONOVISION WITH 2 IOLS OPTION (may still need glasses)

I wish to have a cataract operation with 2 differently-powered IOLs implanted for monovision.

I wish to have my ○ **Right Eye** ○ **Left Eye** corrected for **DISTANCE VISION**

I wish to have my ○ **Right Eye** ○ **Left Eye** corrected for **NEAR VISION**

○ MONOFOCAL IOL OPTION (may still need glasses)

I wish to have a cataract operation with a _____ multifocal IOL implant (state name of implant) on my ○ **Right Eye** ○ **Left Eye**

○ TORIC MONOFOCAL IOL/GLASSES OPTION FOR ASTIGMATISM REDUCTION

I wish to have a cataract operation with a toric monofocal IOL on my ○ **Right Eye** ○ **Left Eye** and wear glasses for ○ **Near Vision** ○ **Distance Vision**

○ LIMBAL RELAXING INCISION FOR ASTIGMATISM REDUCTION (may still need glasses)

I wish to have this procedure done in addition to the cataract operation.

Patient Signature: _____ Date: _____

MTEA Associate: _____ Date: _____

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What to Expect

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WHAT SHOULD YOU EXPECT IMMEDIATELY AFTER CATARACT SURGERY?

Most patients, immediately after cataract surgery, will experience some mild eye discomfort. This includes a scratchy or pressure sensation, which usually lasts for several days. Your vision will usually be blurry for the first several days, gradually improving with time. Some patients experience flashes of light or color; this will improve as the eye heals. Your current glasses prescription may not fit your eyes, and looking through your old glasses may cause your vision to be more blurry than before surgery.

HOW WOULD YOU KNOW IF SOMETHING WERE WRONG?

99.9% of patients that undergo cataract surgery will have no complications after surgery; however, if you experience a sudden loss of vision, or extreme pain, then you should call Dr. Hudson's office immediately.

MEDICATIONS

Besivance: 1 drop in operated eye 2x a day for 2 weeks

Durezol: 1 drop in operated eye 2x a day for 2 weeks (shake well)

Note: Dr. Hudson may change the directions for your medications as needed.

PLEASE DO NOT USE ANY OTHER DROPS THE MORNING BEFORE SURGERY

(Example: drops for glaucoma, allergy drops, etc.) If you were taking other eye drops before surgery, then you may restart these drops immediately after surgery.

EYE SHIELD

We recommend that you wear your eye shield for the **first three nights.** This is to protect the eye while you sleep.

CALL DR. HUDSON OR YOUR OPTOMETRIST IF:

- You develop a sudden decrease or loss of vision
- Severe pain that is not relieved by Tylenol

X: _____

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What to Expect

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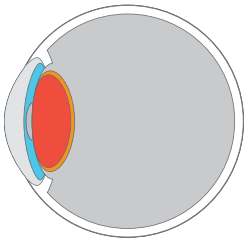
THE CATARACT PROCEDURE

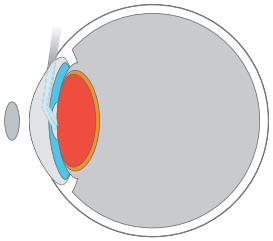
Step 1: Anestesis

You will be completely conscious during the entire procedure, but anesthetic eye drops are applied to numb the eye for surgery and reduce movement. Your eye will then be cleaned with antiseptic and held open with a lid clip. Dr. Hudson will make a very small incision on the outermost edge of the cornea. Your cornea will then be injected with a water-soluble ink for later guidance.



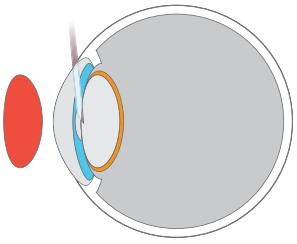
Step 2: Remove Anterior Lens Capsule

You will be given a viscoelastic injection which is a thick jelly-like substance that maintains the shape and pressure of the eye during surgery. To give Dr. Hudson access to the cataract, a round opening is created in the front of the lens capsule.



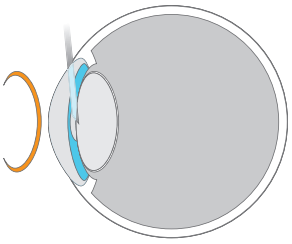
Step 3: Remove Lens Nucleus

A process known as hydrodissection is applied by injecting fluid between the lens and the lens capsule. This loosens and separates the lens. Using a technique called phacoemulsification, an ultrasonic device is used to emulsify (break apart) your cataract before it is aspirated (suctioned) out of your eye and replaced with a salt solution.



Step 4: Remove Residual Cortex

After the removal of the lens nucleus (which makes up 90 percent of the cataract) there are residual fibrous tissues that still have to be removed. These fibrous particles are siphoned out while more salt solution is pumped in. The inside of the lens capsule is buffed and filled up with gel.



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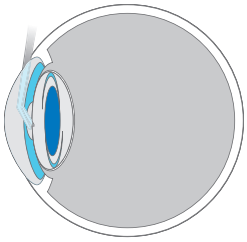
Step 5: Implant Intraocular Lens

After the cataract has been completely removed, Dr. Hudson will insert your new artificial intraocular lens (IOL). The lens will be folded up to allow it to fit through the tiny incision at the edge of your cornea. Once the IOL is inside the lens capsule, it naturally unfolds and positions itself into its correct location inside your eye.



Because of the size of the incision, there are typically no need for stitches. If stitches are required they will normally dissolve within a few weeks or will be removed.

To prevent infection, you will receive an oral antibiotic at the end of your surgery in addition to antibiotic eye drops that are to be used for up to four weeks after your surgery.

The entire length of your surgery typically takes less than fifteen minutes per eye. You should experience no pain and only minimal, if any, discomfort. If you experience any pain during surgery, tell your surgeon. Upon completion of your surgery, you will be taken to a comfortable place where you will be able to rest and relax prior to being discharged to go home. As required by law, you must have a friend or family member available to drive you home.

Informed Consent

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Informed Consent for Laser Cataract Surgery

WHAT IS A CATARACT AND HOW IS IT TREATED?

The lens in the eye can become cloudy and hard, a condition known as a cataract. Cataracts can develop from normal aging, from an eye injury, or if you have taken medications known as steroids. Cataracts may cause blurred vision, dulled vision, sensitivity to light and glare, and/or ghost images. If the cataract changes vision so much that it interferes with your daily life, the cataract may need to be removed. Surgery is the only way to remove a cataract. You can decide not to have the cataract removed. If you don't have the surgery, your vision loss from the cataract will continue to get worse.

HOW WILL REMOVING THE CATARACT AFFECT MY VISION?

The goal of cataract surgery is to correct the decreased vision that was caused by the cataract. During the surgery, the ophthalmologist (eye surgeon) removes the cataract and puts in a new artificial lens called an intraocular lens or IOL. Cataract surgery will not correct other causes of decreased vision, such as glaucoma, diabetes, or age-related macular degeneration. Most people still need to wear glasses or contact lens after cataract surgery for either near and/or distance vision and astigmatism.

WHAT TYPES OF IOLS ARE AVAILABLE?

Your ophthalmologist will help you decide on the type of IOL that will replace your cloudy lens. There are IOLs available to treat nearsightedness (myopia), farsightedness (hyperopia), and astigmatism. IOLs usually provide either near or distance vision: these single focus lenses are called monofocal IOLs. Some newer IOLs can provide for near, intermediate, and distance vision: these multiple focus lenses are called multifocal IOLs. IOLs that treat astigmatism are called toric IOLs. You can also have one eye corrected for near vision, and the other for distance vision, a choice called monovision.

X: _____

Informed Consent

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Informed Consent for Laser Cataract Surgery

WHAT IS ASTIGMATISM? ARE THERE OTHER TREATMENTS FOR IT?

Patients with nearsightedness and farsightedness often also have astigmatism. An astigmatism is caused by an irregularly shaped cornea; instead of being round like a basketball, the cornea is shaped like a football. This can make your vision blurry. In addition to toric IOLs, astigmatism can be reduced by glasses, contact lenses, and refractive surgery (LASIK or PRK). There is also a procedure called a limbal relaxing incision (LRI), which can be done at the same time as the cataract operation, or as a separate procedure. A limbal relaxing incision (LRI) is a small cut or incision the ophthalmologist makes into your cornea to make its shape rounder. Any attempt at astigmatism reduction could result in over- or under-correction, in which case glasses, contact lenses, or another procedure may be needed.

WHAT ARE THE MAJOR RISKS OF CATARACT SURGERY?

- All operations and procedures are risky and can result in unsuccessful results, complications, injury, or even death, from both known and unknown causes. The major risks of cataract surgery include, but are not limited to bleeding; infection; injury to parts of the eye and nearby structures from the anesthesia, the operation itself, or pieces of the lens that cannot be removed; high eye pressure; a detached retina, and a droopy eyelid. The major risks of a limbal relaxing incision are similar to those for cataract surgery, but also include loss of vision, damage to the cornea, and scarring; under- or over-correction could occur.
- Depending upon your eye and the type of IOL, you may have increased night glare or halos, double vision, ghost images, impaired depth perception, blurry vision, and trouble driving at night. The ophthalmologist might not be able to put in the IOL you choose. In addition, the IOL may later need to be repositioned or replaced.
- Depending upon the type of anesthesia, other risks are possible, including cardiac and respiratory problems, and, in rare cases, death.
- There is no guarantee that cataract surgery or astigmatism reduction will improve your vision. As a result of the surgery and/or anesthesia, it is possible that your vision could be made worse. In some cases, complications may occur weeks, months or even years later. These and other complications may result in poor vision, total loss of vision, or even loss of the eye in rare situations. You may need additional treatment or surgery to treat these complications. This additional treatment is not included in the fee for this procedure.

X: _____

Acceptance of Risk

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Acceptance of Risks for Laser Cataract Surgery and IOL Implants

PATIENT'S ACCEPTANCE OF RISKS

I understand that it is impossible for the doctor to inform me of every possible complication that may occur. By signing below, I agree that my doctor has answered all of my questions, that I have been offered a copy of this consent form, and that I understand and accept the risks, benefits, and alternatives of cataract surgery. I have checked my choice for astigmatism correction and type of IOL.

Patient Signature: _____ Date: _____

MTEA Associate: _____ Date: _____

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Promissory Note

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For services rendered to:

_____

By Alissa Craft Hudson, MD of Middle Tennessee Eye Associates, I hereby agree to pay the balance of the accounts listed below:

Patient Name / Account Number / Date of Service	**Balance**
_____	$ _____
_____	$ _____
Total	$ _____

TERMS

I agree that all payments on these accounts will be made in accordance with the following terms:

Date of first payment: _____

Due date of additional payments: _____

Number of payments: _____

Monthly payment amount: _____

If payments are not made as agreed, Middle Tennessee Eye Associates will declare all remaining installments due and payable with ten (10) days and hereby stipulate to judgment in any court of competent jurisdiction for such amount. In the event this agreement is placed in the hands of an attorney or collection agency for collections through legal proceedings or otherwise, I agree to pay collection fees, attorney's fees and court cost.

*I understand and agree that at this time, the full amount of this note might not be known, and I agree to pay the full final amount of the balance of my account. I certify that I have read the foregoing, received a copy thereof, and am duly authorized by the aforementioned patient to execute the above and accept the terms.

Patient / Guarantor: _____ Relationship to Patient: _____

MTEA Associate : _____ Date: _____

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Anesthesia Consent

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Monitored anesthesia care is provided during your surgical procedure. This is a specific service in which an anesthesia provider has been requested to participate in the care of a patient undergoing a therapeutic procedure. Each provider tailors the anesthetic experience to his/her preference of drugs and to the patient's specific needs.

THE ANESTHESIA PROVIDER:

- Monitors vital signs, maintains the patient's airways, support of vital functions
- Diagnoses and treats clinical problems which can occur during the procedure
- Administers sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety
- Provides psychological and physical comfort
- Provides other medical services as needed to accomplish the safe completion of the procedure

I understand anesthesia will be used during my procedure and I agree to receive anesthesia and be monitored during surgery.

Patient / Guarantor: _____ Date: _____

MTEA Associate : _____ Date: _____

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Financial Disclosure

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For billing purposes, there are separate service components for which you or your insurance will be billed:

PHYSICIAN'S FEE

The physician will bill this charge separately to you. This billing is for the professional services that are provided during your procedure by the physician. This will come directly from the physician's office.

FACILITY FEE

There will also be a bill from the facility for the use of the ambulatory surgery center in which your procedure is being performed. The approximate facility fee for your procedure is determined by your insurance. If the procedure requires additional services, the billing will be increased depending on the added requirement. This will come directly from the surgical center.

ANESTHESIA FEE

The anesthesia provider is non-related to this facility and will also be billing charges separately. Often facilities use independent providers. You will be billed for services directly from the provider that performed your anesthesia.

I understand the above charges, which have been discussed. Furthermore, I understand that I am responsible for my balance in full.

All co-pays, deductibles, or premium lens fees are due before services are rendered. If you have questions please discuss them with your coordinator. There is a $150 rescheduling fee for ANY cancelled surgeries. If you have questions, please discuss them with your coordinator.

Patient / Guarantor: _____ Date: _____

MTEA Associate : _____ Date: _____

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Before Your Surgery

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DAY OF CATARACT SURGERY

1. The surgery center will call you with your arrival time.
2. You are responsible for co-pays and deductibles as your insurance states in your plan. Make any needed payment arrangements as soon as possible.
3. You have a prescription for after surgery drops. Please pick it up at your pharmacy on or before your surgery day.
4. **Do not eat on surgery day.**
5. If you are on blood pressure medication, take it on surgery day.
6. You have a one day follow up appointment. Come to it as scheduled.
7. Return any unsigned paperwork to Dr. Hudson's office as soon as possible.

X: _____

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Before Your Surgery

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You are scheduled for cataract surgery on your (right / left) eye on _____.
Surgery on your (right / left) eye will be on _____.

Surgery will take place at **Perimeter Surgery Center**.
Perimeter Surgery Center will call you the FRIDAY before your surgery with your arrival time.
(931) 646-7058 | 1059 Neal Street, Suite B. Cookeville, TN 38501

DAY OF SURGERY

1. Wear a button up shirt/blouse and comfortable bottoms.
2. **DO NOT EAT OR DRINK ANYTHING 6 HOURS BEFORE SURGERY.**
3. Wash your face and remove all make-up/debris from your eyes.
4. Diabetics: Avoid taking your regular dose of medication for diabetes.
5. Bring a driver with you the day of surgery. **THEY MUST REMAIN AT THE SURGERY CENTER DURING YOUR SURGERY.** Someone should stay with you the first 24 hours after surgery.

AFTER SURGERY INSTRUCTIONS

6. After surgery eye drops are to be used 2 times per day for 14 days starting the day of surgery.
7. For any increase in pain, redness, or decrease in vision, call Middle TN Eye immediately. **(931) 372-1994** or **(888) 848-0741**
8. It is normal to have blurry vision after cataract surgery. You will probably experience light and color changes as well. **DO NOT RUB OR PRESS THE EYE AFTER SURGERY!**

THINGS TO REMEMBER:

- You will receive an "After Surgery" bag
- Wear the provided eye shield to bed for the first 3 nights

X: _____

After Surgery Care

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THE DO'S:

Reading
Walking
Watching TV
Biking
Golfing/Fishing
Dancing
Jogging/Running
Tennis/Bowling
Travel by Plane
Lifting

⚠ THE DON'TS:

Rub or Press on Eye
Avoid Extreme Dust
Avoid Chemicals
Avoid Water/Soap for Three Days

POSTOPERATIVE EYE CARE SCHEDULE

To be sure that your eye is healing properly, you will need to be examined at regular intervals. Please be sure to keep following your appointment schedule with your optometrist or Dr. Hudson. Glasses will be prescribed 2-3 weeks after surgery.

VISIT #1	**1 Day After Surgery**
VISIT #2	**1 Week After Surgery**
VISIT #3	**1 Month After Surgery**

CONTINUING CARE

Dr. Hudson recommends a **yearly dilated exam**.

If you develop any problems with your eyes, please call Middle Tennessee Eye Associates: **931-372-1994** or **888-848-0741.** We will be happy to see you any time and answer any questions.

X: _____

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Photo Permission

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Dr. Alissa Hudson and the staff at Middle Tennessee Eye Associates are excited you chose us for this life changing experience. We will document your surgery with a photo. Sometimes these photos are used in advertisements. We often use television, internet, and print ads to advertise this practice. To agree to have your image used sign below. If you decline the use of your image sign the appropriate line below. You can also like us on Facebook and tell people about your experience.

Thank you,

Donna Kernell, CoA OSC

Donna Kernell, CoA, OSC

Surgical Coordinator

I Agree: _____ Date: _____

I Decline: _____ Date: _____

Signature: _____ Date: _____

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Location

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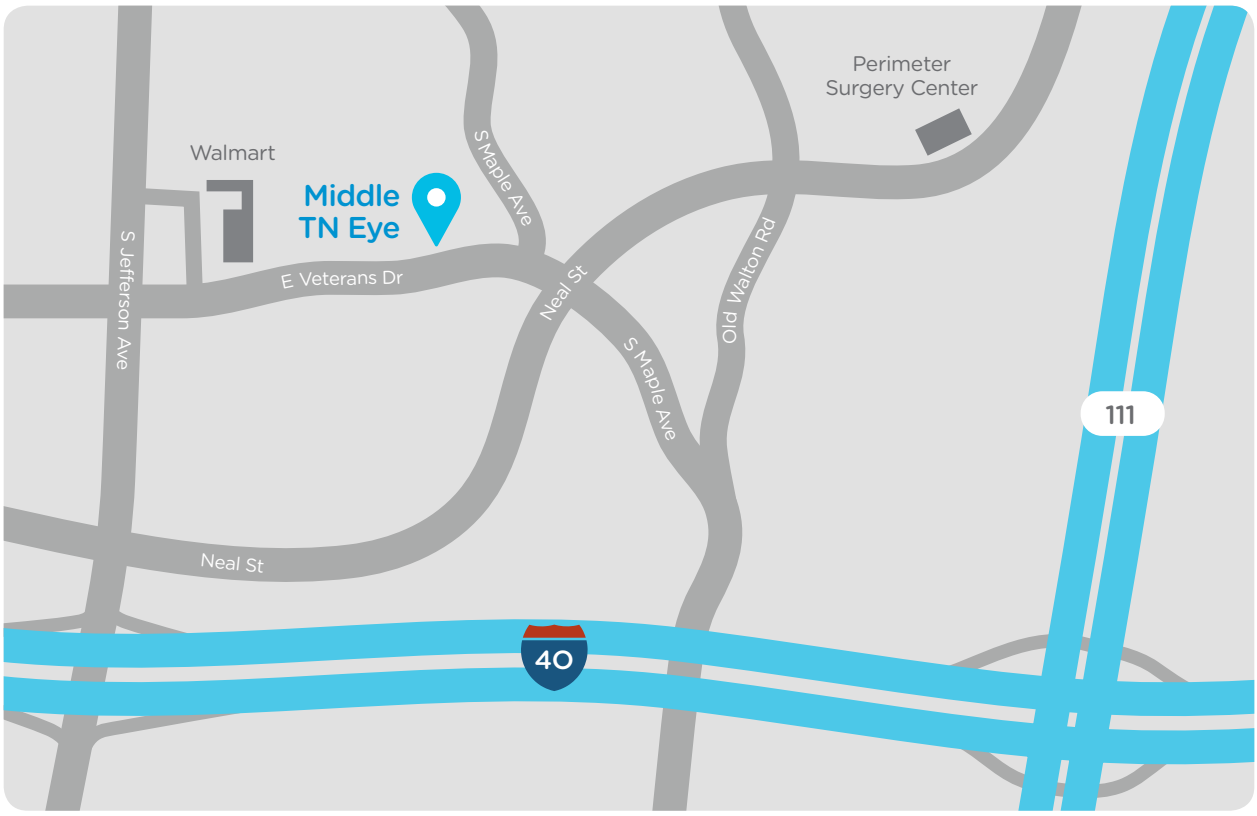

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