NIELSEN EYE CENTER
CENTER FOR SIGHT

THE NIELSEN EYE CENTER
COMANAGEMENT SURGICAL PATHWAY

1. Your Patient has an Eye Problem needing NEC Surgical Services.

2. An Appointment is made either by the optometrist or the patient calling The Nielsen Eye Center at 617-237-4040. The optometrist faxes **Patient Referral /PRE-POST-Operative Evaluation Form** to The Nielsen Eye Center to 617-665-6703 or 617-665-6704.

3. Our Surgeon determines the best procedure for the patient after a thorough eye evaluation exam. The surgeon makes a recommendation for the patient. Exam notes including surgical recommendations are faxed to the referring optometrist through EMR system.

4. The Patient sits with our Patient Advocate who goes over paperwork, scheduling of surgery, and finances. The patient signs Consent for OD Co-management Form.

5. If they are a cataract patient, they come back for an A-scan, and make a decision on surgery. At this appointment, our Patient Advocates will call your office to schedule post-op appointments.

6. The patient undergoes surgery for the first eye. The Patient is seen by their surgeon one-day post operatively. The patient is seen by their surgeon one day postoperatively after the second eye. The postoperative evaluation is faxed to the referring optometrist through EMR.

7. The patient is seen by the referring optometrist thereafter. **Patient Referral /PRE-/POST-Operative Evaluation Form** is sent back to Nielsen Eye Center.

8. For Medicare and commercial insurance, the Optometrist office will bill applicable insurance or Medicare with the 55 Modifier. For Refractive surgery, if the patient elects to be co-managed, the referring optometrist will be responsible for collecting $500 from the patient for post-operative appointments during the global period following their one-day postoperative appointment with The Nielsen Eye Center. This includes one month, six-month, and one-year postoperative appointments.

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Patient Referral/PRE-/POST-Operative Evaluation

▫ Referral _____ ▫ PRE-Operative Evaluation _____ ▫ POST-Operative Evaluation _____

Patient_____ Date_____

Date of Birth _____ Telephone # _____

▫ INSURANCE _____ ▫ POLICY # _____

▫ CATARACT ▫ LASIK ▫ OTHER

CC:_____ **Meds:**_____

_____ _____

Visual Acuity (unaided)
OD 20/
OS 20/

Manifest refraction (PRN)
OD
OS

Near Vision (IOL upgrade)
OD
OS

Slit Lamp Examination

OD		**OS**	
Lids/Lashes	▫Clear Other	Lids/Lashes	▫Clear Other
Conjunctiva	▫ Clear Other	Conjunctiva	▫ Clear Other
Cornea	▫ Clear Other ▫ No Striae Other ▫ No DLK Other	Cornea	▫ Clear Other ▫ No Striae Other ▫ No DLK Other
Anterior Chamber	▫ Clear Other	Anterior Chamber	▫ Clear Other
Iris	▫ Clear Other	Iris	▫ Clear Other
Lens	▫ Clear ▫ Cataract ▫ PCIOL Centered	Lens	▫ Clear ▫ Cataract ▫ PCIOL Centered

▫ **Educated Patient on Lens Choices including Laser Cataract Astigmatic Correction, Toric Lenses, and Multifocal Lenses. Educated as to benefits, risks, and side effects. (IOL upgrade)**

Assessment **Plan**

_____ _____

_____ _____

Name_____ Signature_____

Please Fax Back to 617-665-6704

NIELSEN EYE CENTER
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CONSENT FOR OPTOMETRIC CATARACT CO-MANAGEMENT

Date: _____ Fax #: _____

Dear Dr. _____ Patient Name: _____

Date of Birth: _____

I had the opportunity of seeing the above captioned patient for evaluation of gradual, progressive blurred vision, which is now interfering with the ability to see clearly. A full evaluation was done including slit lamp examination and dilated fundus examination. Cataracts were found to be the cause of the loss of vision.

Impression: Visually significant cataracts, interfering with visual functioning.
I have discussed the risks, benefits, and alternative forms of treatment for cataract surgery, and the patient has seen a video on cataract and implant surgery. The patient expresses understanding of the surgery and the patient's questions have been answered. I will fax you a note postoperatively once the patient is stabilized.

Cataract surgery on the right eye has been scheduled for _____ and the left eye has been scheduled for _____, subject to change.

The patient is scheduled for post-operative follow-up on the right eye on _____ and for the left eye on_____.

Steven Nielsen MD / Helen Moreira MD / Nitasha Khanna MD / Shobha Topgi, MD

- ❑ ***I agree to having my optometrist co-manage my postoperative care. I can return to my surgeon if I have any issues or concerns***
- ❑ ***I DO NOT agree to be co-managed by my referring optometrist and will keep all post-operative appointments with The Nielsen Eye Center.***

Patient Signature: _____Date: _____

Thank you kindly for your confidence and your continued referrals.
Dr. Steven Nielsen, M.D. Dr. Nitasha Khanna, M.D.
Dr. Helen Moreira, M.D. Dr. Shobha Topgi, M.D.

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CONSENT FOR LASIK CO-MANAGEMENT

Date: _____ Fax #: _____

Dear Dr. _____, Patient Name: _____

Date of Birth: _____

I had the opportunity of seeing the above patient for a refractive surgery evaluation. LASIK surgery for the right/left or both eyes has been scheduled for _____, subject to change.

On examination, the intraocular pressures were normal, and the corneas were clear. The posterior pole on dilated indirect ophthalmoscopy and bio-microscopic evaluations revealed a normal cup to disc ratio, maculae, and vascular tree and periphery. Topographic evaluation was within normal limits, as was evaluation for dry eyes, and large scotopic pupils. The patient is an ideal candidate for refractive surgery.

Impression: Ideal candidate for Custom All-Laser LASIK Surgery or Advanced Surface Ablation.

I have discussed the risks, benefits, and alternative forms of treatment for LASIK surgery and the patient has seen a video on Custom All-Laser LASIK surgery. The patient expresses understanding of the surgery and the patient's questions have been answered. I will fax you a note postoperatively once the patient is stabilized.

The patient is scheduled for post-operative follow up _____.

Steven Nielsen, MD. / Helen Moreira, MD. / Nitasha Khanna, MD.

- ❑ ***I understand and agree to having my optometrist comanage my care and will compensate them $500 for any postoperative appointments following my one day with Nielsen Eye Center, during the Global period. These include one month, six-month, and one year postoperative appointments.***

- ❑ ***I understand and <u>DO NOT</u> agree to be co-managed by my referring optometrist and will keep all post-operative appointments with The Nielsen Eye Center.***

Patient Signature _____ **Date** _____

Thank you kindly for your confidence and your continued referrals.
Dr. Steven Nielsen, M.D. Dr. Nitasha Khanna, M.D.
Dr. Helen Moreira, M.D.

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THE NIELSEN EYE CENTER
SURGICAL REIMBURSEMENT

Cataract and other Intraocular Surgery is performed at the Cataract and Laser Center, 333 Elm Street, Dedham:

Procedures:

OD Co-Management Fee

Cataract Post-Operative Care–Regular or Multifocal,

Medicare & Commercial Bill with 55 modifier

Refractive Surgery – Lasik, Visian, Monovision is performed at Quincy Laser Eye Center, 300 Congress Street, Quincy.

Procedures:

Lasik, EVO ICL	$500 from patient pending patient co-management agreement

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THE NIELSEN EYE CENTER
CO-MANAGEMENT SERVICES AGREEMENT

On behalf of the doctors at The Nielsen Eye Center, we appreciate the trust you have placed in us to co-manage the care of your patients. To streamline the referral and co-management process, this document will act as a continuous co-management agreement for the remainder of the calendar year of 2023 between the referring Optometrist and Ophthalmologist. Please complete, sign, and return to the Nielsen Eye Center at your earliest convenience. This document represents an agreement to co-manage care for all patients referred to The Nielsen Eye Center for Refractive and Cataract surgery, unless we receive written notice from the referring Optometrist otherwise per patient, or if the patient chooses to forego co-management and continue care within the Nielsen Eye Center.

I understand that for any Cataract post-operative co-managed care, I will be responsible for billing the patient's insurance with a 55 modifier to receive co-management payment from the patient's insurance provider.

I understand that I will be responsible for collecting $500 directly from the patient for Refractive surgery postoperative care, following their one-day post op with Nielsen Eye Center, for the global period – this includes one month, six-month, and one year post operative appointments if the patient elects to be co-managed.

Optometrist Name: (print) _____

Signature: _____Date: _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ Fax: _____