NIELSEN EYE CENTER
CENTER FOR SIGHT

THE NIELSEN EYE CENTER
COMANAGEMENT SURGICAL PATHWAY
(10 checks to proper Co-Management)

1. Your Patient has an Eye Problem needing NEC Surgical Services and you may educate the patient on lens choices.

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** (***Check 1***) to The Nielsen Eye Center to 617-471-7041 or 617-665-6704. If the patient calls to schedule the appointment, we try to always ask who referred patient. (***Check 2)***

3. The Patient shows up for appointment, and is asked who referred them by front receptionist (***Check 3).***

4. Our Patient is worked up by a Technician, and as part of the work up is asked who referred the patient, how did patient find out about The Nielsen Eye Center (***Check 4***)

5. Our Surgeon determines the best procedure for the patient after a thorough eye evaluation exam. The Surgeon finds out how patient found us, or who referred (***Check 5***). The surgeon makes a surgical recommendation for the patient. Exam notes including surgical recommendations are faxed to the referring optometrist through EMR system. (***Check 6***).

6. The Patient sits with our Patient Advocate who goes over paperwork, scheduling of surgery, and finances. The patient signs Consent for OD Cataract Co-management Form. ***(Check 7)***

7. If they are a cataract patient, they come back for an A-scan, and make decision on surgery. At this appointment, our Patient Advocates will call your office to schedule post-op appointments. (***Check 8***)

8. The patient undergoes surgery for first eye. The Patient is seen by their surgeon one-day post operatively. A surgery is scheduled on the second eye, if necessary. 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. (***Check 9***)

9. The patient is seen by the referring optometrist thereafter. **Patient Referral /PRE-/POST-Operative Evaluation Form** (***Check 10***) is sent back to Nielsen Eye Center – this triggers **Co-management Check** for Commercial Insurances. Check is cut when Insurance pays for surgical services (can take up to 90 days) and patient has paid their responsibilities.

10. For Medicare patients, the Optometrist office will bill Medicare with the 55 Modifier. If it is commercial insurance, The Nielsen Eye Center will bill the insurance carrier and reimburse the referring optometrist 20% of amount collected.

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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)	**Manifest refraction (PRN)**	**Near Vision (IOL upgrade)**
OD 20/	OD	OD
OS 20/	OS	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 COMANAGEMENT

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. The patient would like to return to your excellent care postoperatively, once the eye is stabilized. This will benefit the patient from both from a geographical convenience, optical convenience, and for continuity of care. I will fax you a note postoperatively once the patient is stabilized prior to transferring them back to your care.

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_____in your office or will they will call to set up appt.

I understand that my optometrist will be co-managing in my post-operative care, but I can return to my surgeon if I have any issues or concerns. **Steven Nielsen MD / Helen Moreira MD**

Patient Signature: _____Date: _____

I agree to co-manage this patient and to notify the surgeon should any complications arise and to provide written progress reports during the post-operative period. Directions: *Please sign and fax this form back to The Nielsen Eye Center (Fax) 617-665-6704.*

Optometrist Signature: _____Date: _____

Thank you kindly for your confidence and your continued referrals.
Dr. Nielsen, M.D.
Dr. 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**	Bill with 55 modifier (see "Co-Management of Postoperative Care" by Corcoran Consulting Group
Cataract – Single Focus IOL – No Laser, **Commercial**	20% of amount collected from insurance.
Cataract – All Upgrades, **Commercial**	20% of amount collected from Insurance + $100/eye

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

Procedures:	
Lasik, Visian	Per Eye Payment - $1100 (ASC fee) x20% (OU would be double)

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"The Doctor, the Technology, and the Service your Patients deserve."

Why Co-Manage with The Nielsen Eye Center?

- Patients can expect skilled doctors, the latest technology and superb customer service.
- The Nielsen Eye Center has performed more than 50,000 successful refractive procedures.
- Drs. Nielsen, Moreira, and Werdich meet with each and every patient at their first consultation and will remain their surgeon and doctor during the entire process.
- A dedicated Patient Advocate works to maintain a strong communication link to all referring Optometrists.
- This partnership can be financially beneficial to your practice, with our competitive reimbursement rates.

"Bringing together the optometrist and the ophthalmologist to work cooperatively to best serve the interest of the patient."

- The Nielsen Eye Center provides a complimentary van service for surgical appointments to those who need transportation.
- The Nielsen Eye Center has Cantonese, Mandarin, Vietnamese, Spanish, and Portuguese translators.

For more information about The Nielsen Eye Center, please visit our website at: **www.GoLasik.net** and call our Patient Advocates, at 877-373-2020 to learn more about this beneficial co-management partnership.

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THE NIELSEN EYE CENTER
CO-MANAGEMENT SERVICES AGREEMENT

I hereby authorize The Nielsen Eye Center to collect pre- and post-operative fees on my behalf from each patient for whom I provide pre- and post-procedure care for vision correction procedures.

Optometrist Name: (print) _____

Signature: _____ Date: _____

The Nielsen Eye Center should make my co-management fee checks to the following:

Check Payable To: _____

Tax ID: (for year-end 1099) _____

Address: _____

City/State: _____

Zip Code: _____

Telephone: _____

Fax: _____

Please list any additional OD's that will be comanaging under the tax ID listed above:

_____

_____

_____