MARION EYE CENTERS - CONSENT FOR PROCEDURE

PATIENT: _____CHART: _____DATE: _____

I hereby authorize Dr. _____ or whomever the doctor may designate to perform the procedure.

INTRAVITREAL INJECTION OF ANTIVEGF AGENT (AVASTIN, MACUGEN, LUCENTIS, EYLEA, OR BEOVU) TO THE RIGHT EYE AND/OR LEFT EYE FOR ONE YEAR

If any unforeseen condition arises in the course of the procedure, calling on their judgment for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.

I understand and accept the nature and purpose of the procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications including endophthalmitis, decrease in vision, blindness, enucleation, chronic pain, permanent disability, and death. This has been fully explained to me and I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

I certify that I have read and fully understand the above Consent, and that all blanks or statements requiring insertion of completion were filled in before I affixed my signature. I have been encouraged to discuss the risks and complications with my family before proceeding with the procedure.
I understand and accept that other qualified, competent licensed Marion Eye Center ophthalmologists and/or optometrists other than the performing ophthalmologist may provide my post-operative care. I understand I may choose to return to my provider at any time for post-operative care.

I understand that use of Avastin for ocular use is not FDA approved. I understand that the “off label” use of Avastin has been researched and that it can be used to treat conditions such as macular degeneration, diabetic retinopathy, and retinal vein occlusion. Avastin may not be safe for a fetus and women of childbearing age who may be or become pregnant the patient should discuss these risks with the treating doctor.

SIGNED: _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PROCEDURE)

WITNESS: _____

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the Marion Eye Center for any services furnished. I authorize any holder of medical information about me to release to the CMS or my insurer and its agents any information needed to determine these benefits or benefits payable for related services.

INSURANCE: _____PREAUTHORIZATION: _____