

Huffman and Huffman –Eye Care Center, LLC

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Eye Physicians and Surgeons * Consultative Ophthalmology

Dr's. James G. Huffman, M.D., Mark D. Huffman, M.D., James M. Huffman, M.D., Rebekah Huffman, D.O., & Justin West, M.D.

Patient Name: _____ Surgeon: _____

I voluntarily, knowingly, and willingly elect to have a portion of my post-operative care provided by: _____ for the following reason:

- ☐ It is my preference.
- ☐ My surgeon will be on an extended leave of absence and another provider must manage my post-operative care
- ☐ It is a hardship to travel to the surgeon's office for the post-operative visits.
- ☐ Surgery was performed in health professional shortage area (HPSA) and I am unable to travel to surgeon's office for post-operative care.
- ☐ An Itinerant surgeon in a remote area of the country performs the surgery.

I understand that Dr. _____ has agreed to provide my surgeon with a copy of my medical record after each post-operative visit. The co-managing provider is entitled to bill Medicare for a portion of the post-operative care. I have been informed that I can contact my surgeon's office at any time for any questions and/or problems, and if I choose to return to my surgeon at any time during the post-operative period, I may do so. I understand that I will only be co-manage if and when my surgeon deems it appropriate. All questions have been answered to my satisfaction.

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____