



The Eye Center of Fort Wayne

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Patient Consent Form

(Post-operative care)

I consent to have surgery performed at the Eye Surgical Center of Fort Wayne.

I understand my pre-operative and immediate post-operative evaluations will be performed by doctors at The Eye Center of Fort Wayne.

I understand post-operative evaluations are necessary. I have been given the option of continuing my post-operative care with my personal optometrist or remaining in the care of the Eye Center of Fort Wayne. I understand my post-operative fee will not be affected by my decision.

In the event of co-management with my optometrist, I request the transfer of care only when medically appropriate. I understand the doctors at the Eye Center of Fort Wayne may be contacted should postoperative concerns occur.

I consent to complete my postoperative care with:

My optometrist, Dr _____

The Eye Center of Fort Wayne

My decision is based primarily on:

Convenience

Location

Secure with quality of

Insurance purposes

Optometrist does not participate in co-management

Patient Signature: _____

Patient name: _____

Witness: _____

Date: _____