Surgery Day Checklist

Treatment Day: _____ Arrival Time: _____

One day follow-up date is scheduled for _____ at _____

Last day to wear contacts: _____

How do I prepare for my treatment?

- Find a driver. You NEED a driver to bring you, stay with you and take you home.
- Read and Sign all of your paperwork. There are four consent forms (Informed Consent, Vision for Life, Rights and Responsibilities, What to Expect on Surgery Day).
- **Fill your prescriptions ONE WEEK BEFORE YOUR TREATMENT**

1. **Vigamox-RX** (antibiotic) a.k.a. Moxifloxacin
   Place one drop in eyes(s) to be treated. Use the NIGHT BEFORE and the MORNING of your surgery.

2. **Pred Forte-RX** (anti-inflammatory) a.k.a. Prednisolone
   This drop is to be used after treatment.

3. **Preservative Free Eye Drops** a.k.a Artificial Tears
   These drops are OTC (over the counter). You need two boxes of 25-30 count individual vials. These are to be used after treatment.

TIP: Go to goodrx.com OR Google the names of your medications to check for available rebates or discounts.

Day of Your Treatment

You will be in our office for one and a half hours. Please note, arrival times are tentative and may change.

A minimum of 72 hours notice is required for all appointment changes.**

- Eat before your treatment.
- Do not wear make-up, cologne, perfume, scented lotions.
- Do not drink caffeine the day of your procedure.

****DISCLAIMER**
If you cancel or reschedule your appointment less than 72 hours prior, a $250 fee will be required before you reschedule ($200 of that will serve as a deposit toward your surgery).

Payment Options

Total Cost of Your Surgery

$_____ minus deposit of $_____

Due at surgery

$_____

price guaranteed for 30 days after consultation

Financing Options

Alphaeon apply at alphaeoncredit.com

We offer 24 months 0% interest with monthly payments as low as $99/ mo (per eye).

Care Credit apply at carecredit.com

We offer 12 months 0% interest with monthly payments as low as $198/ mo (per eye).

Wells Fargo apply at wellsfargohealthadvantage.com

We offer 24 months 0% interest with monthly payments as low as $99/ mo (per eye).

When applying...

- Easily apply directly through our website under the 'Payment' tab.
- Financing must be arranged BEFORE your surgery day.
- Bring your account number or card to your appointment.
- You do not choose the monthly payment option when you apply. We do that in office on your surgery day when we process your payment.

Other Options

- Visa, MasterCard, American Express, Discover
- FSA (Flex Spending Account) or HSA (Health Savings Account)
- Cashiers Check or Money Order (make payable to Keil Lasik Vision Center)
- NO personal checks or cash accepted

When preparing your payment...

- Call your bank associated with card to pre-authorize this transaction. (Reason being, most cards have a daily or transaction limit).
- Limit of TWO forms of payment.
- Payment is made in FULL on your day of surgery.

Keil Lasik Vision Center

VISION FOR LIFE

PATIENT GUIDE

Our Lifetime Commitment to You

WHAT IS VISION FOR LIFE?

VISION for Life is our commitment to you that we stand behind your vision results for life.
We have confidence in our surgeons and in the stability of our patients' results over the long term.
Our intention is to help you maintain the best possible vision throughout your lifetime. The primary benefit of the VISION for Life program is our assurance that if an enhancement is medically advisable to maintain vision results, eligible and participating patients are entitled to the surgical enhancement procedure with any VISION for Life surgeon nationwide, at no charge.

WHO IS ELIGIBLE FOR THE VISION FOR LIFE PROGRAM?

You are eligible if you are in good general eye health and have had your initial laser eye treatment at a VISION for Life center by a VISION for Life–affiliated surgeon. Please read the program's detailed guidelines for complete information. To maintain eligibility in the VISION for Life program, you need to have an annual eye exam performed by your eye doctor.

WHAT IF I REQUIRE AN ENHANCEMENT AND THE TECHNOLOGY HAS CHANGED?

If you have maintained eligibility in the VISION for Life program and originally had a Custom LASIK procedure, you are eligible for a Custom LASIK enhancement at no charge. However, if the LASIK technology required for your enhancement has advanced since your original procedure, you will be charged the difference in retail cost between the old and new technologies.

WHAT IF I DO NOT MEET THE VISION FOR LIFE ELIGIBILITY AND EXCLUSION GUIDELINES?

If an enhancement is medically advisable within 12 months of your procedure and you do not meet the VISION for Life eligibility and exclusion guidelines listed below, you will still receive; a 50% discount off our usual and customary fees for the enhancement procedure. Additional fees for post-operative care may apply. The fees will be determined by the VISION -affiliate doctor and must be paid to the doctor by the patient.

HOW DO I ENROLL IN THE VISION FOR LIFE PROGRAM?

Eligible patients are automatically enrolled in the VISION for Life program upon completion of their laser vision correction procedures. The VISION for Life Passport and Guidelines will be provided on the day of your procedure. You must sign a VISION for Life Commitment Acknowledgment stating you understand the conditions of the program.

ELIGIBILITY GUIDELINES

Laser Vision correction patients must meet the following criteria to be eligible and to maintain -eligibility for the VISION for Life program:

1. The patient must be treated at a VISION for Life center for his or her initial procedure by an eligible VISION for Life-affiliated surgeon and have a myopic spherical equivalent of -10.00 D or less and/or astigmatism of no greater than -3.00 D at the time of treatment, or the patient must have a hyperopic spherical equivalent of a +4.00 D or less and/or astigmatism of no greater than a -2.00 D at the time of treatment.

2. The patient must have a best corrected (aided) vision of 20/40 distance vision or better prior to the laser refractive procedure.

3. The patient must have followed the complete course of post-operative treatment required during the first 12 months after the procedure (initial and enhancements, if any), including post-operative follow-up visits, as prescribed by the VISION for Life–affiliated surgeon and affiliated eye doctor.

4. The patient must be current in all payments due to Keil Lasik or its affiliates for laser vision correction.

5. Following completion of the post-operative treatment period of 12 months, the patient must have annual eye exams with an eye doctor and document each visit on the VISION for Life passport provided to each patient. Fees for the annual eye exams are determined by the patient's doctor. NOTE: Fees for annual exams are the responsibility of the patient.

6. The patient understands that the surgeon who performed the original procedure may not be available for the enhancement; if that is the case, another surgeon will be recommended.

7. The VISION for Life–affiliated doctor and treating surgeon must agree that it is medically advisable to pursue the enhancement requested by a patient. In the event of a difference of medical opinion between them, the ultimate decision as to medically advisability is made by the VISION for Life–affiliated surgeon.

EXCLUSIONS

Although we expect many patients to be eligible for the VISION for Life program, there are -exceptions or conditions under which further refractive procedures are ill advised. These patients, as described below, will not be eligible for the VISION for Life program:

1. Patients whose refractive error falls outside the Eligibility Guidelines. Refer to #1 in Eligibility Guidelines above.

2. Patients whose loss of vision is a result of an accident involving trauma to the eye.

3. Patients whose vision is reduced due to irregular astigmatism.

4. Patients who had RK, ALK, or other refractive procedures, prior to having laser vision correction.

5. Patients whose initial laser vision correction was not performed at a VISION for Life center.

6. Patients diagnosed with an ocular disease such as cataract, glaucoma, diabetic retinopathy, retinal tear or detachment, ectasia, or macular degeneration.

7. Patients seeking an enhancement as a result of developing or progression of presbyopia, even though presbyopia is a result of natural changes in vision.

8. Patients of surgeons who do not participate in the VISION for Life program.

9. Patients who fail to comply with the VISION for Life eligibility guidelines.

INCLUDED IN THE LIFETIME COMMITMENT PROGRAM

- Your fee for your vision correction procedure includes post-surgical care for up to one year following the initial procedure. This post-surgical care must take place at participating centers. (Ask your center for details.)

NOT INCLUDED IN THE LIFETIME COMMITMENT PROGRAM

The patient is responsible for the following:

- Travel-related costs.
- Costs of annual exam after surgery.
- Costs of any visits unrelated to the standard LASIK post-surgical care, even within the first year.
- Pre- and post-operative care for an enhancement, unless this care occurs within the first year following the patient's initial procedure.
- Costs for treatment of monovision patients who elect to change their target refraction.

Keil Lasik Vision Center

Acknowledgement of Receipt and Review of Membership Guidelines

By signing this form, I acknowledge the following:

☐ I have received a copy of the VISION for Life Guidelines.

☐ I understand the program and have had all my questions answered to my satisfaction.

☐ I understand that my initial procedure includes post-surgical care for one year following the surgery and annual exams or visits unrelated to standard post-surgical care are NOT included in this post-surgical care.

☐ MONOVISION PATIENTS ONLY: Based on the VISION for Life™ eligibility guidelines, I understand that if I elect to have a monovision target changed, a charge will be applied.

Please initial:

☐ _____ National Lifetime Care. Based on the VISION for Life eligibility and exclusion guidelines, I understand that I am eligible to participate in the program as outlined.

_____	_____
Patient Signature	VISION for Life Staff Member Signature
_____	_____
Patient Signature (print)	VISION for Life Staff Member Signature (print)
_____	_____
Date	Date

Informed Consent

Keil Lasik Vision Center

616.365.5775 www.keillasik.com

INFORMED CONSENT FORM

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR LASER EYE SURGERY; PLEASE READ IT CAREFULLY BEFORE YOU SIGN IT.

You are entitled to receive information about the proposed LASIK/PRK treatment you intend to undergo, whether it be for MYOPIA (nearsightedness), with or without astigmatism, or HYPEROPIA (farsightedness), with or without astigmatism. It is important that you understand the risks of each of these treatments and carefully weigh the alternatives prior to undergoing a LASIK/PRK procedure. LASIK/PRK (collectively, "Laser Vision Correction') are all permanent operations to the cornea and the results may not be reversible. Laser Vision Correction removes small amounts ot tissue from your cornea to reshape your eye. This tissue cannot be replaced.

You should have already received and carefully read the Patient Information Booklet and reviewed the Patient Information Video. They describe the types of surgical procedures available to you, the benefits and risks of each type of procedure and the potential complications associated with laser eye surgery. If you have not received the Patient Information Booklet, please ask for one to be provided to you. It is important that you read and understand its contents before your surgery. By initialing here, you acknowledge that you have read and understand the contents of the Patient Information Booklet and reviewed the Patient Information Video. Initials

Our initial eye examination is designed to determine if you are a candidate for Laser Vision Correction surgery. After further testing or additional consideration of your medical history, we may determine that a different procedure that originally recommended is appropriate or that you are not a good candidate for Laser Vision Correction surgery. Additional examination/testing by another doctor may also be recommended.

If you have any questions regarding your procedure, please discuss them fully with your doctor prior to surgery. You may want to seek a second opinion before undergoing this procedure.

KEIL LASIK VISION CENTER OPTIONS

Photorefractive Keratectomy (PRK) uses the excimer laser, which produces a beam of light to remove thin layers from the cornea to reshape it after the surface layer (epithelium) has been removed. This surface layer will grow back with the assistance of a bandage contact lens.

Laser Assisted in Situ Keratomileusis (LASIK) uses a microkeratome, femtosecond or similar alternative technology to create a corneal flap on the surface of the eye. The flap then is opened like the page of a book to expose tissue just below the cornea's surface. Next, the excimer laser is used to remove thin layers from the cornea to reshape it. Finally, the flap is returned to its original position, without sutures.

PATIENT TREATMENT STATEMENT

CHECK ONE:

___I have MYOPIA (nearsightedness), with or without astigmatism, which requires me to wear corrective lenses in order to see clearly for my daily activities. I have been informed of the alternatives to undergoing the surgical option I have chosen, including eyeglasses, contact lenses and other types of refractive surgery.

___I have HYPEROPIA (farsightedness), with or without astigmatism, which requires me to wear corrective lenses in order to see clearly for my daily activities. I have been informed of the alternatives to undergoing the surgical option I have chosen, including eyeglasses, contact lenses and other types of refractive surgery.

I have elected to undergo and give permission for the following procedure to be performed on me:

___LASIK ___PRK ___ENHANCEMENT of Previous Procedure

EYE(S) TO BE TREATED: ___Both (OU) ___Right Eye (OD) ___Left Eye (OS)

_____ _____

Patient's Name (Please Type or Print) Date

_____ _____

Patient's Signature Physician's Signature

PATIENT SAME DAY SURGERY STATEMENT

I have been offered the opportunity for same day surgery today. I understand there are disadvantages to same day surgery including less time for me to think about my decision and less opportunities for repeat testing prior to treatment which may affect my results. Upon careful consideration, I have voluntarily elected to have my procedure performed on the same day as my examination. I am comfortable that I have been given ample opportunity to read all the educational information (including the Patient Information Booklet), watch the Patient Information Video and have all my questions answered.
I feel adequately informed and comfortable to make this decision today. Initials

The main reason(s) I want same day surgery include(s): *Please check all that apply and place initials in box.*
___Convenience ___Less time off work ___Less travel time ___Other (please specify below)

Other:_____

_____ _____
Patient's Signature Date

PATIENT ACKNOWLEDGMENTS

I understand and acknowledge, by my initials below, the following:

1. BENEFITS AND OUTCOME NOT GUARANTEED.

The benefits of laser vision correction procedures cannot be guaranteed. The goal of LASIK and PRK is to reduce or eliminate myopia (with or without astigmatism) or hyperopia (with or without astigmatism). The outcome in my case cannot be guaranteed. I have read and understand the contents of the Patient Information Booklet. There are no guarantees that I will completely eliminate my reliance on eyeglasses and/or contact lenses or that my eyesight will be improved at all.
If I want an enhancement procedure in the future, I realize that in some cases it may not be possible. In order to perform an enhancement surgery, there must be adequate tissue remaining. If there is inadequate tissue, it may not be possible to perform an enhancement. An assessment and consultation will be held with the surgeon at which time the benefits and risks of an enhancement surgery will be discussed. Enhancement procedures have higher risks of ectasia, epithelial ingrowth and other complications. If I am a clinically appropriate candidate for enhancement in the future, my surgeon will not proceed until I am sufficiently healed and stable in my vision to allow for an enhancement. Initials

2. SURGICAL RISKS AND POSSIBLE SIDE EFFECTS:

OVER-RESPONSE OR UNDER-RESPONSE TO TREATMENT. It is possible that my treatment could result in an unintended under-response or over-response that may require the continued use of glasses or contact lenses after my surgery has been performed.

CHANGE IN OR INDUCING ASTIGMATISM. The surgical procedure I am undergoing may also change my astigmatism or induce an astigmatism even if I did not have one prior to the procedure.

INFECTION OR INFLAMMATION. Although infrequent, another risk is the possibility of infection or inflammation during the healing of the cornea. This may result in permanently decreased vision. I understand that to achieve good results from the procedure, it is important that I follow my doctor's recommendations regarding post-operative medications, activities and restrictions.

HAZE. Some patients experience haze (or corneal cloudiness). Haze is not the initial blurriness experienced immediately after treatment. Rather, haze may become evident in the weeks and months after surgery. PRK procedures have higher risks of haze than LASIK. Haze is difficult to treat and may result in loss of best-corrected visual acuity, including permanent loss of visual sharpness or clarity.

NIGHT GLARE. I may experience night glare, as a "starburst," a "halo effect," or haze around lights in the nighttime. Some degree of night glare can be expected in many patients. It usually is tolerable and resolves in time but on occasion could be permanent. Patients with high myopia or high astigmatism are at a greater risk of experiencing these problems, as are patients with large pupils. Dry eyes, as well as over or under response, may also result in night glare.

NIGHT VISION. Vision may not seem as sharp at night as during the day. In some cases, corrective lenses may help me see clearly at night. Corrective lenses may not be able to compensate for some loss of night vision. Initials

INCREASED SENSITIVITY. There may be an increased sensitivity to light or glare.

BLURRINESS. Blurriness is common in the healing process. While blurriness generally clears in several days, it may take longer to clear and could remain permanently.

LOSS OF BEST-CORRECTED VISUAL ACUITY. There is a risk of loss of best corrected visual acuity. For most patients, visual acuity will have stabilized in about 3 to 6 months, although full recovery, especially for PRK, may take 4 to 12 months. A small percentage of patients develop irregular corneas that reduce the sharpness, clarity and crispness of their vision. If this happens, I may not be able to read the last few lines of the eye chart, regardless of corrective lens assistance.

CORNEAL FLAP COMPLICATIONS. There is also a small risk I may develop a corneal flap complication. A flap complication may require my procedure to be stopped or postponed for several months. I have read the information in the Patient Information Booklet regarding these complications and understand these risks. Initials

LASIK FLAP RE-LIFTING PROCEDURES may be required after my original procedure for conditions such as flap striae or wrinkles, debris, epithelial ingrowth, inflammation or other reasons.

READING GLASSES. If I am over 40 years of age and have laser vision correction to correct both eyes for distance vision, I will likely need reading glasses in order to see objects approximately 3 feet and closer, either now, or sometime in the next several years. This condition is called Presbyopia and it begins to affect most people after the age of 40. If I am age 40 or older, I acknowledge that I have requested and received a separate education sheet on Presbyopia. I understand that Monovision, like reading glasses, is one of several solutions for Presbyopia and if I am considering Monovision, I have requested and received a separate informed consent form for Monovision. Initials

DRYNESS. I may experience dryness of my eyes and this dryness may cause severe irritation, discomfort and blurring of vision for several weeks or longer and could rarely be permanent. I may need to use artificial tears, eye ointments, prescription medication or punctual plugs for an indefinite period of time. Post menopausal women may be at higher risk for developing dry eyes. Some medications may also cause dry eyes. Initials

DOUBLE VISION. I may experience double or ghosted vision, which may go away with time. If it does not go away, I may need enhancements after my procedure, which may or may not help this issue.

ECTASIA or KERATOCONUS. I could develop keratoconus, in which the cornea progressively begins to thin and bulge. Keratoconus is a degenerative corneal condition affecting vision. Keratoconus can be difficult to diagnose in its early stages and if I have keratoconus and laser vision correction surgery, the degeneration of my cornea might or might not accelerate. I may develop keratoconus even if I do not have Laser Vision Correction surgery. My cornea could also become weakened from the thinning of laser vision correction and begin to bulge and take on an irregular shape. This is known as ectasia. While there are several tests that suggest which patients might be at risk, these conditions can develop in patients who have a normal preoperative profile regarding the shape and thickness of their cornea. There is no way to completely eliminate the risks of ectasia with LASIK or PRK. Patients having LASIK are at higher risks for ectasia than patients having PRK. My doctor may recommend PRK as a way to lower the risk of ectasia but there is no guarantee that I will not develop this condition. Keratoconus or ectasia can distort vision. Severe keratoconus or ectasia may be treatable with a corneal transplant, while mild keratoconus or ectasia may be treatable with special contact lenses. Initials

FURTHER TREATMENT. Further treatment, including hospitalization, may be necessary. Further treatment could include a variety of eyedrops, the wearing of glasses and/or contact lenses (hard or soft), or additional surgical or laser correction (enhancements). Follow-up visits will be required. If I do not follow my doctor's orders regarding follow-up care, I may be jeopardizing the healing process or long term health of my eye(s).

EQUIPMENT MALFUNCTION. The microkeratome or femtosecond (in LASIK) or the excimer laser (in LASIK and PRK) could malfunction, requiring the procedure to be stopped before completion. In some instances, the malfunction may not be detected until after the procedure. Depending on the type of malfunction, this may or may not be accompanied by visual loss.

RISK TO BOTH EYES. If I have both eyes treated on the same day, complications could develop in both eyes at the same time. As a patient, it is my choice for treatment of one eye at a time or both eyes on the same day.

OTHER COMPLICATIONS. As with all types of surgery, there is a possibility I may experience other complications, including those due to drug reactions. I have discussed this possibility with the staff and understand that it is impossible to be informed of all potential risks of any surgery, including laser vison corrective procedures. I have provided my surgeon and the staff with complete and up to date information regarding prescription and over the counter medications I take, any drug allergies and my pre-existing medical conditions, including prior surgeries, degenerative conditions, active or pre-existing eye disorders and any previous eye treatments. Complications may occur that require addition medical care, treatments, tests, medicines or surgery and this care or surgery may be at my expense. Initials

3. CONTRAINDICATIONS. Treatment may not be indicated in every person. The situations in which treatment is contraindicated are fully described in the Patient Informational Booklet and include the following:

Contraindications:

- Unstable refraction
- Certain abnormalties of the cornea (e.g., keratoconus or other corneal ectasias, thinning, edema, interstitial or neurotrophic keratitis, extensive vascularization)
- Abnormal corneal topography with a diagnosis of keratoconus or other corneal ectasias
- Insufficient corneal thickness for the proposed ablation depth
- Irregular astigmatism (e.g., corneal warpage)
- Advanced visually significant cataract
- Uncontrolled glaucoma
- Uncontrolled external disease (e.g. blepharitis, dry eye, allergy)
- Uncontrolled connective tissue or auto immune disease
- Unrealistic patient expectations
- Orbital, lid, or ocular anatomy that precludes proper function of the microkeratome or femto laser
- Under 18 years of age

Relative Contraindications- those conditions that are evaluated individually by the doctor and include the patient's history, current clinical situation and pre-existing health conditions:

- Functional monocularity
- Ocular conditions that limit visual function
- Overly steep or flat corneas
- Corneal stromal or endothelial dystrophies
- Poor epithelial adherence, anterior basement membrane dystrophy, or recurrent erosion syndrome
- History of herpes simplex or zoster keratitis
- Dry eye syndrome. This includes, but is not limited to, the rare patient who had dry eyes without contact lenses and must use artificial tears multiple times a day. (Patients who have difficulty wearing contact lenses due to dry eye should inform their doctor.)
- Prior incisional or lamellar keratorefractive surgery
- Pupil diameter in dim illumination that is greater than the planned ablation diameter
- Glaucoma
- Poorly controlled diabetes mellitus or ocular complications of diabetes mellitus
- Pregnancy or lactation
- Connective tissue or autoimmune diseases, systemic immunosuppression. Persons with autoimmune diseases, such as lupus and rheumatoid arthritis, will be at higher risk of complications from laser vision correction.
- Certain systemic medications (e.g., isotretinoin, amiodarone, sumatriptan, levonorgestrel implants, colchicines)
- Significant occupational or recreational risk for corneal trauma
- History of severe eye infection or active eye infection

4. CONFIDENTIALITY.

The confidentiality of my protected health information (medical information) is protected by both federal and state laws, but may be used for purposes of treatment, payment and health care operations of my doctor(s) and staff. I acknowledge I have received a Notice of Privacy Practices. My protected health information may be used in the study and analysis of Laser Vision Correction surgery but my identity will be kept confidential and will not be used in any reports or journal articles.

☐ Initials

5. FDA APPROVAL.

With the recommendation of my doctor, the laser can be used to perform laser vision correction outside of the FDA guidelines, including when treatment may be otherwise contraindicated, as explained above and in the Patient Information Booklet. This is routinely done both internationally and in the United States. If I am undergoing laser vision correction and have a prescription outside of the approved ranges or with contraindications, I understand and accept the risks of doing so.

☐ Initials

6. FDA APPROVAL FOR MEDICATIONS.

With the recommendation of my doctor, an antimitotic (anti-cancer) medication known as Mitomycin-C (MMC) may be applied to the cornea after PRK to reduce the potential for corneal haze. MMC, when used this way, is used "off label" from the FDA guidelines, meaning it is for an indication that has not yet received FDA approval. MMC has been used for other eye related surgeries (glaucoma filtration and pterygium surgeries) since the 1980's to prevent scarring. Extensive clinical experience has shown that MMC may be effective in reducing the incidence and severity of corneal haze after PRK. MMC is a potent and potentially toxic antimitotic under certain circumstances. There are no guarantees as to the success of the procedure in removing or preventing corneal haze. There is a possibility that serious toxic side effects, among other complications, may develop.

☐ Initials

PATIENT STATEMENT OF INFORMED CONSENT

I have read the Patient Information Booklet and this Informed Consent document (or they have been read to me) and I understand them.

I have been given adequate time to thoroughly review and understand the Patient Information Booklet and this Informed Consent and acknowledge that I fully understand all the potential risks and complications discussed in the informed consent, including but not limited to those I may have failed to specifically initial.

I have watched the Patient Information Video describing the procedure and understand the information presented in the Video.

I have had the opportunity to have all my questions answered regarding the procedure. I am satisfied and ready to proceed with the procedure.

My treatment will be performed by an independently contracted, board certified or board eligible doctor who specialized in ophthalmology, licensed by the state.

It is not possible for my doctor to inform me of every conceivable complication that may occur during my procedure.

I have been given the opportunity to meet with my laser vision correction surgeon in addition to my examining doctor prior to the procedure if I so request.

I understand and accept the risks and potential complications associated with the procedure and understand that my doctor may be treating me beyond the FDA-approved guidelines for the laser being used.

I understand and accept the risk that the long-term effects associated with LASIK/PRK are not fully known.

_____	_____
Patient's Name (Please Type or Print)	Date of Birth
_____	_____
Patient's Signature	Date
_____	_____
Physician's Signature	Date
_____	_____
Witness' Signature	Date

I AGREE TO <u>TURN OFF</u> MY CELL PHONE, PAGER OR RADIO BEFORE ENTERING THE LASER SUITE ☐

Initials

KEIL LASIK VISION CENTER
NOTICE OF PRIVACY PRACTICES
EFFECTIVE Dec 16, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our goal is to take appropriate steps to attempt to safeguard any medical and personal information that is provided to us. By law, we are required to maintain the privacy of medical information provided to us, provide notice of our legal duties and privacy practices, and abide by the terms of this notice.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as your name, address, phone number, medical history, insurance information, and information regarding other medical providers. In addition, we will be collecting data about you during our examinations, which will be contained within your medical record. Some information may also be provided to us by other individuals or organizations that are part or your "circle of care" -such as the referring physician, other doctors, your health plan and close friends or family.

HOW INFORMATION MAY BE DISCLOSED

We may use and disclose personal and identifiable health information for a variety of purposes including treatment planning, billing, and health care operations (such as internal audits). We sometimes work with outside business associates. We may disclose your health information so they can perform the tasks that we hire them to do. They must promise to respect the confidentiality of your personal and identifiable health information.

We are required by law to provide information in cases of review by the Secretary of Health and Human Services in determining our compliance with privacy laws or when served with a subpoena, court order or warrant. We also may disclose information in cases of public health issues, child or other abuse cases, or if necessary to prevent a serious heath and safety threat to yourself or others.

Your information may be released to workers' compensation or similar programs, which provide benefits for work-related injuries or illnesses without regard to fault. If you are an inmate, we may release protected information to the correctional institution if it is deemed necessary for your treatment or the health and safety of yourself or others.

Your personal information may be used by the office to contact you regarding upcoming or missed appointments, give updates on insurance issues, test results and treatment options.

We may disclose information to the individuals involved in your care including your spouse, your doctors or an aide who may be providing services to you. In case of an emergency situation, we may make disclosures without your agreement. If you sign an authorization to disclose information to another individual or company, you may revoke it in writing and stop any future uses and disclosures.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting in your care or payment for your care. We will consider your request, but are not required to accept it.

You have the right to request that you receive communications containing your personal information by alternative means or locations (such as only by mail or only at home). Such requests must be made in writing.

If you believe information in your record is incorrect or incomplete, you have the right to ask us to correct or amend the information. Under certain circumstances, we may deny your request, such as when the information is accurate and correct.

Except under certain circumstances, you have the right to inspect and obtain copies of your medical records and billing information. You may be charged a fee for copying and mailing.

You have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make and used and disclosures before Dec 16, 2009, among others. If you ask for this information more than once every 12 months, you may be charged a fee.

You have the right to a copy of this notice in paper form at any time. To exercise any of your rights, please notify us in writing at:

Keil Lasik Vision Center
2500 East Beltline SE, Suite C
Grand Rapids, MI 49546

COMPLAINTS

If you have any complaints regarding our privacy practices, you may contact our privacy officer at the above address, or the Secretary of the Department of Health and Human Services at 200 Independence Ave. Room 509F, HHH Big, Washington DC 20201. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

We reserve the right to make changes to this notice at any time. In the event of a change, the revised notice will be posted. You may also request a copy.

PATIENT'S RIGHTS AND RESPONSIBILITIES

Following is a list of your Right and Responsibilities as a patient. At Keil Lasik Vision Center, we strive to ensure that your rights are met. If you have any questions regarding this information, please discuss your concerns with a staff member.

As a patient, you have the RIGHT to:

- Provision of healthcare regardless of race, sex, color, national origin or disability
- Considerate and respectful care
- A reasonable response to your request and need(s) for service
- Information regarding your diagnosis, treatment and known prognosis
- Participate in decisions involving your healthcare, unless medically contradicted
- Know the identity and professional status of individuals providing services to you
- Refuse to participate in research or training projects
- Receive information regarding your proposed treatment in order to give informed consent
- Reasonable privacy and information confidentiality, within the law
- Refuse treatment and be informed of the medical consequences of such action
- Expect and receive reasonable continuity of care, including continuing health needs after discharge
- Appoint a responsible person to act on your behalf if the need arises
- Receive an itemized bill for all services
- Report any comments regarding quality of services and receive their prompt attention

As a patient, you are RESPONSIBLE for:

- Providing to the best of your knowledge, accurate and complete information about your present health status and past medical history and to report any unexpected changes to your practitioner
- Following the treatment plan recommended by the practitioner primarily responsible for your care and bringing to their attention any reason for inability to follow the treatment plan
- Indicating whether you clearly understand a contemplated treatment plan and what is expected of you
- Your actions if you refuse treatment or decide not to follow the recommended treatment plan
- Following the rules and regulations of the facility and being considerate of other patients' rights
- Assuring that the financial obligations of your health plan is fulfilled expeditiously

I understand my Rights and Responsibilities as a patient and have no further questions.

Patient Signature:_____**Date:**_____

Keil Lasik Vision Center

616.365.5775
www.keillasik.com

WHAT TO EXPECT ON YOUR TREATMENT DAY

- Prior to your treatment, you will receive numbing eye drops (local anesthetic) to prevent discomfort. These drops will eliminate pain, but it is normal to feel pressure sensations.
- The non-treated eye may be patched or taped closed to better align the eye being treated.
- It will take a few minutes to properly position you under the microscope. A lid speculum will be used to prevent any blinking. This may be a little uncomfortable but not painful.
- You will be asked to focus on a light throughout the procedure. Dr. Keil will monitor your eye through the microscope at all times. Dr. Keil controls the laser and it is normal to start and stop occasionally during treatment.
- During the first part of the surgery, Dr. Keil will place a ring on your eye that will hold your eye still during creation of the flap/pocket. You will feel pressure on your eye and your vision may go dark.
- In the second part (LASIK ONLY) you will hear a vacuum sound accompanied by a tapping sound as the laser gently alters the refractive curvature of your eye.
- Immediately after treatment, antibiotic and anti-inflammatory drops are placed in the treated eye(s).
- Sunglasses will be provided to wear after surgery and the first 3 nights while sleeping.
- Please go directly home after your treatment. A nap or keeping BOTH eyes closed for 2-4 hours can help relieve discomfort. It is normal to experience a burning sensation during this period, as the numbing drops wear off.
- When you wake up, remove the sunglasses and begin using several drops according to the discussed schedule. You should continue to use artificial tears **at least** 4 times per day for 3 weeks regardless of whether you have dryness or not.
- Medicine, eyedrops and their medical names may be changed by Dr. Keil.
- **DO NOT RUB** or squeeze your eyes. This could cause discomfort and possible damage.
- You may experience the following sensations after your treatment:
    - *Burning* – This usually occurs within the first hour after treatment and could last up to 4 hours. You may feel as though you're wearing a dirty contact lens or your eyes may feel sandy or scratchy. **DO NOT RUB THEM!**
    - *Watering/Tearing* – Your eyes will probably water or tear. This could happen for the first couple of days. Just dab gently **around** your eyes, and keep using tears!
    - Red/Swollen Eyes – Your eyes may be slightly red and swollen during the first 48 hours. This is perfectly normal.
    - *Blurriness/fluctuation* – Your vision **in one or both eyes** may be blurry for the first 48 to 72 hours after Lasik and 2-4 weeks after the Inlay. This is **normal** and will eventually stabilize.
    - *Ghosting/Glaring* – During the first week after your treatment, your vision may fluctuate slightly or you may experience some ghosting or glare. This is normal and will usually improve.
    - *Light Sensitivity* – You may experience increased sensitivity to light for a few days after treatment. Sunglasses will help.

_____

Sign **Date**

Keil Lasik Vision Center