GULFCOAST EYE CARE
www.GulfcoastEyeCare.com

2650 Tampa Road, Palm Harbor, FL 34684 | Office: (727) 785-4419 | Fax: (727) 789-3351
6036 Park Boulevard, Pinellas Park, FL 33781 | Office: (727) 549-2105 | Fax: (727) 768-0488
1515 9th Ave N., St. Petersburg, FL 33705 | Office: (727) 895-2020 | Fax: (727) 823-8796

CO-MANAGEMENT PROTOCOL

❍I participate with Medicare and third party insurances and wish to provide pre and post-operative care at my facility as designated herein.

❍I do not participate with the following insurances but wish to provide pre and post-operative care at my facility as designated herein.
❍ Medicare ❍ BC/BS ❍ United ❍ Aetna ❍ Humana ❍ Cigna

❍Other Commercial

❍I wish to provide pre and post-procedure care at my facility for the following procedures: _____

❍ YAG❍"All-Laser" LASIK❍Superficial Keratectomy/PTK
❍Basic Monofocal Lens❍PRK❍Pterygium Excision
❍Astigmatism Correcting Lens❍Implantable Contact Lens (ICL)
❍Multifocal/Accommodating Lens❍Refractive Lens Exchange

As the co-managing physician, I understand and agree to the following:

1.I confirm that this is not an agreement to refer and that the co-management fees below are based on a fair market value to services rendered by a co-managing physician and not an inducement to refer patients.

2.I confirm that I will be providing post-operative care on behalf of Gulfcoast Eye Care.

3.If I **do not participate** with my patient's insurance but wish to provide post-operative care on behalf of Gulfcoast Eye Care, I will provide the care as an Independent Contractor. Gulfcoast Eye Care will bill Medicare and/or third party insurances for total care and will allocate a portion of the fee for post-operative care.

4.If I **do not participate** with my patient's insurance, I will not bill Medicare and/or third party insurances for post-operative care.

5.If I **do participate** with my patient's insurance, I understand it is my responsibility to bill co-management directly to Medicare and/or third party insurances for post-operative care.

6.I will provide post-operative follow-up care for my **Basic Monofocal Lens Patient** at 1 day second eye, 3-4 weeks, 3-4 months and any other follow-up visits which the patient may require during the 90-day post operative period. After each post-operative appointment I will send my findings, including visions at all distances with and without refraction, to Gulfcoast Eye Care.

7.I will provide post-operative follow-up care for my **Astigmatism Correcting Lens/Multifocal Accommodating Lens Patient** at 1 day second eye, 3-4 weeks and 3-4 months post-operative appointment and any other follow-up visits which the patient may require during the 90-day post operative period. After each post-operative appointment I will send my findings to Gulfcoast Eye Care as follows:

Refraction

Distance, Intermediate, and Near Vision for each eye and bilateral with and without refraction

a.Measure intermediate vision at 32”

b.Measure near vision at clearest distance for patient

c.Near vision through distance Rx

8.I will provide post-operative follow-up care for my **LASIK Patient** at 1 day, 1 week, 1 month and 3 months and any other follow-up visits which the patient may require during the post-operative period.
After each post-operative appointment I will send my findings to Gulfcoast Eye Care as follows:

Refraction

Distance and Near Vision for each eye and bilateral (for a Monovision patient measure Bilateral Distance and Bilateral Near)

a.Measure near vision at clearest distance for patient

9.I will provide post-operative follow-up care for my **PRK Patient** at 1 day, 1 week (CL Removal), 1 month and 3 months and any other follow-up visits which the patient may require during the post operative period.
After each post-operative appointment I will send my findings to Gulfcoast Eye Care as follows:

Refraction

Distance and Near Vision for each eye and bilateral (for a Monovision patient measure Bilateral Distance and Bilateral Near)

a.Measure near vision at clearest distance for patient

10.I confirm that I am a licensed optometric physician in good standing in the State of Florida. I am knowledgeable about cataract surgery and laser vision correction and its risks and benefits. I am responsible for the care which I render to my patients. I maintain professional liability insurance with a Florida licensed insurance company.

11.I will immediately report any complication or adverse events (i.e., infections, haze, intraocular pressure in excess of 25 mmHg, etc.) to the respective surgeon.

12.I understand that Gulfcoast Eye Care will pay the co-management fees 2 weeks following the receipt of post-operative notes for the second eye post-operative visit.

13.Co-management fees should be made payable to:

Practice Name (Please print)	Physician Name(s)	
Street Address	City	Zip Code
Telephone	Fax	NPI#
Date	Tax	

Physician Signature

PLEASE RETURN COMPLETED FORM BY FAX: (727) 823-8796

Email to correctivevisionsurgery@gulfcoasteyecare.com