CO-MANAGEMENT OF PERI-OPERATIVE CARE

Date: ☐ nJoy Vision OKC		
Doctor:		TIN/SSN:
Practice Name:		NPI:
Address:		
City, State:		Zip:
Phone:	Fax:	Lic#
Email:		
Secure ONC Email:		

When medically appropriate, I agree to provide pre/post operative care for refractive surgical patients. I agree to keep the surgeon informed of the progress of the patient by providing post-operative reports after each visit to the appropriate location.

My fees for co-management are as follows:

LASIK/PRK $_____ per eye

ICL $_____ per eye

Intacs $_____ per eye

CXL $_____ per eye

Refractive Package 90 day extended post-op care

Advanced $_____ per eye

Custom $_____ per eye

I agree to refund the patient any fees for unused follow up visits.

This is not an agreement to co-manage any specific patient. Any such agreements will be entered into in each instance among the surgeon, the patient and myself. The purpose of this agreement is to inform nJoy Vision of my fee for co-management in order for NJOY OKC, LLC to advise the patient and collect the fee on my behalf.

_____ _____

Referring Doctor's Signature Date

Please fax information to: OKC 405.842.6130