

Experience. The Difference.

## **EXPERIENCE THE CLEAR CHOICE CUSTOM LASIK CENTER DIFFERENCE.**

Welcome to Clear Choice Custom LASIK Center. You've made an exciting and important decision to celebrate life with LASIK. Your Clear Choice Custom LASIK Center Vision Team is dedicated to ensuring your entire LASIK experience is a positive and enjoyable one. Here's what you can look forward to today...

### **1. Free Screening**

The first step in your LASIK journey is the free screening. Using some simple tests, we'll make a preliminary determination as to whether you are a candidate for laser vision, and to assess some of your particular vision correction needs. It's quick, easy and completely free.

### **2. Consultation**

Following your screening, your Vision Consultant will meet with you to discuss the results. You'll learn what course of treatment is best for you and what options might be available. And you'll be quoted an exact fee. You can then schedule your procedure and secure your special price.

### **3. Scheduling**

Scheduling your procedure requires a deposit. We accept checks and all major credit cards for payment, and we offer an excellent financing program. With your payment, we'll offer you our next available procedure dates and times, so you can make an appointment that fits your schedule.

### **4. Pre-Operative Exam**

During a preoperative exam, your Clear Choice Vision Team utilizes state-of-the-art diagnostics to assess your specific eye and vision requirements for the LASIK procedure.

If you have your contacts out for the prescribed amount of time (see Rules for Contact Lenses on page 3), and if an optometrist is on staff, we may be able to perform your Pre-Op exam the same day as your free screening. If not, it can be rescheduled for another day. The pre-op exam takes approximately 2 hours. A dilating drop is used - **note that your eyes may remain dilated for as long as 48 hours.**

If you are not prepared to schedule your procedure today, simply call our office when you're ready. A list of surgery dates is available at the front desk.

Your entire Clear Choice Vision Team is dedicated to you and your vision. We're here to guide you through this exciting, life-enhancing experience. Let us know if you have any questions. We're here to help!



# PREPARING FOR YOUR PROCEDURE

## Before You Arrive

- On the day of your procedure, eat and drink lightly and avoid caffeine.
- Please do not consume any alcoholic beverages.
- Please do not wear any make-up or jewelry.
- **Please do not wear any perfume, lotions, cologne or after shave.**
- Dress warm - note that the laser room is kept cool.
- Wash eyelashes and eye lids thoroughly the morning of your procedure.
- Please be sure to arrange for assistance getting home.

## After You Arrive

- You will be here for an hour and a half to two hours.
- Note that your time in the surgery suite is about 7 minutes per eye.
- When the procedure is complete, transparent "shields" are taped over your eyes for protection while you sleep. Wear these for the first day, then for the following 3 nights.
- We will provide you with protective sunglasses, because you will be sensitive to light after surgery.
- You will be given post-operative instructions and confirm your 1 day post-operative exam.
- When you leave Clear Choice, please try to sleep so your eyes will be at rest and heal faster. You will start all your drops when you wake up.



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## **RULES FOR CONTACT LENSES**

You must be out of your contacts for as least the following length of time prior to your pre-operative exam and surgery.

### ***If you wear standard soft lenses***

Prior to Pre-Op Exam:	No contact lenses for 5 days
Prior to LASIK Surgery:	No contact lenses for 14 days

### ***If you wear Toric soft lenses (weighted for astigmatism)***

Prior to Pre-Op Exam:	No contact lenses for 10 days
Prior to LASIK Surgery:	No contact lenses for 14 days

### ***If you wear hard lenses or gas permeable lenses***

Prior to Pre-Op Exam and Surgery: No contact lenses for a minimum of 8 weeks.

(Note that several topography or STABLE Wavescan test appointments will be needed to check progress for hard or gas permeable lenses)

**\*Please note that these are guidelines, NOT guarantees. Clear Choice/TLC will determine your specific time out of contacts based on your screening results.**



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## RELEASE AUTHORIZATION

To ensure continued superb results, Clear Choice uses pre operative and post operative results to continually monitor and guide laser performance. This data is also used to guide surgeons around the world to help them achieve optimal results. We ask your permission to use your treatment data for this purpose. Furthermore, we would like to ask your permission to potentially use images of your eye for studies and or journal articles. Signing below gives the doctor and staff permission to obtain, display, and or print medical information or images from the chart of the undersigned patient. We will not include personal or patient identifying images or information.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Email: \_\_\_\_\_

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Name (printed) \_\_\_\_\_

The patient or person signing for the patient named above acknowledges receipt of a federally-required Notice of Privacy Practices, provided to you under the provisions of the Health Insurance Portability and accountability Act of 1996.

\_\_\_\_\_  
Signature



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# PATIENT INFORMATION

By completing the information below, you are giving authorization for Clear Choice Custom LASIK Center and its affiliates to contact you in the future.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Company Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Email (if available): \_\_\_\_\_

## 1. Do you have any of the following health problems?

Rheumatoid Arthritis	YES	NO
Diabetes	YES	NO

2. Are you pregnant or nursing or have you nursed in the last 6 months? YES NO

## 3. Have you ever had any of the following eye diseases?

Keratoconus	YES	NO
Herpes Keratitis	YES	NO
Glaucoma	YES	NO

## 4. If you wear contact lenses, please complete the following:

Soft Lenses	____/____/____	Last date worn
Hard Lenses	____/____/____	Last date worn
Gas Permeables	____/____/____	Last date worn
Toric Lenses	____/____/____	Last date worn



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5. Do you sleep in your contact lenses? YES NO
6. Do you wear bifocals? YES NO
7. Do your eyeglasses have prism in them? YES NO
8. Have you ever had any experience wearing contact lenses for monovision? (for patients over age 40)  
YES NO
9. I am interested in Financing YES NO
10. I am interested in correcting my vision in:  0-3 months  6-12 months
11. Do you have specific concerns about your eyes that you'd like us to know about?

12. Are you a veteran or a member of the military? YES NO ACTIVE RETIRED
13. Are you a law enforcement officer/fire fighter/EMT? YES NO ACTIVE RETIRED

To assist us with our marketing, please share with us how you heard about Clear Choice Custom LASIK Centers.

PLEASE BE SPECIFIC

Event: \_\_\_\_\_

Direct Mail: \_\_\_\_\_

Radio: \_\_\_\_\_

Facebook: \_\_\_\_\_

Internet: \_\_\_\_\_

Seminar: \_\_\_\_\_

Patient Referral \_\_\_\_\_

Doctor Referral \_\_\_\_\_

Other: \_\_\_\_\_



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## TELL US ABOUT YOUR EYE DOCTOR

**I don't have a regular eye doctor (If you don't have a regular eye doctor check this box and skip this form. You may continue on the next page.)**

At Clear Choice it's our mission to provide you with the best possible care and to make you feel comfortable throughout your entire LASIK experience. Clear Choice Custom LASIK Center has many long-standing relationships with eye doctors throughout the country. Many of them have participated in our ongoing continuing education programs and training. We would like to know more about your previous care and your eye doctor.

**Has your eye doctor mentioned that you were a candidate for LASIK?**

**Yes**

**No**

**Would you prefer to have all of your care at Clear Choice , or would you prefer to include your eye doctor in your LASIK experience?**

**Include my eye doctor**

**At Clear Choice**

**If you selected "include my eye doctor", would you like to include them:**

*(select none, one or both)*

**Pre-operative exams**

**Post-operative exams**

**Who is your current eye doctor?**

**Eye Doctor's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_

**When was your last eye exam? :** \_\_\_\_\_

***For Office Use Only:***

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