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9050 University Pkwy
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MILLS
EYE +
FACIAL SURGERY

David M. Mills MD, FACS
Ophthalmologist +
Facial Plastic Surgeon

YAG PC (Posterior Capsulotomy) Consent Form

- 1) I, _____, hereby authorize:
David M. Mills, MD, FACS and/or whomever he may designate as his assistant(s), to perform upon myself the following operation(s):

YAG PC (Posterior Capsulotomy)

a) Right Eye Left Eye Both Eyes

2) **WHAT ARE THE MAJOR RISKS OF YAG LASER SURGERY?**

- a) All operations and procedures are risky and can result in unsuccessful results, complications, injury, or even death, from both known and unknown causes. The major risks of cataract surgery include, but are not limited to pain, bleeding, infection, blood clots, loss of vision/eye, blindness, loss of life (death), persistence/recurrence of lesions/symptoms, glaucoma (high eye pressure), double vision, nerve damage, muscle damage, tearing, light sensitivity, risk of anesthesia including cardiac and respiratory problems, and, in rare cases, death, injury to parts of the eye and nearby structures, scarring, asymmetry, need for further surgery, especially if there are pieces of the lens that cannot be removed, a detached retina, a droopy eyelid, allergic reaction, as well as risk of transfusion reactions and the transmission of infectious disease, including hepatitis and acquired immune deficiency syndrome from the administration of blood and/or blood components and others. The ophthalmologist might not be able to put in the IOL you choose. In addition, the IOL may later need to be repositioned or replaced.
- b) Anesthesia risk:**
- i) Depending upon the type of anesthesia, other risks are possible. Your anesthesiologist should be consulted for a comprehensive discussion of these risks.
- c) No Guarantee:**
- i) Although good results are expected, there is no guarantee or warranty expressed or implied, on the results that may be obtained. There is no guarantee that cataract surgery or astigmatism reduction will improve your vision. As a result of the surgery and/or anesthesia, it is possible that your vision could be made worse.
- d) **Bleeding-** It is possible, though unusual, that you may have problems with bleeding during or after surgery. Should post-operative bleeding occur, it may require emergency treatment to drain accumulated blood or require a blood transfusion. Please discontinue aspirin or anti-inflammatory medications as instructed by the prescribing physician if possible before surgery, as this contributes to a greater risk of bleeding. However, given the modern techniques used for cataract surgery, this is less significant now than in times past. Non-prescription "herbs" and dietary supplements can increase the risk of surgical bleeding. Hypertension (high blood pressure) that is not under good medical control may cause bleeding during or after surgery.
- e) **Infection-** Infection is unusual after this surgery. Should an infection occur, additional treatment including antibiotics or surgery may be necessary. Pain is

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the hallmark of infection. Should you have pain out of proportion to the situation or that is progressively worsening, please attempt to notify us immediately or proceed to your nearest emergency room. Other symptoms would include headache, decreasing vision, tearing, light sensitivity, a red eye (more than just the usual bruise from surgery), etc.

- f) **Damage to deeper structures**- Deeper structures such as blood vessels, muscles, and particularly nerves may be damaged during the course of surgery. The potential for this to occur varies with the type of procedure performed. Injury to deeper structures may be temporary or permanent.
- g) **Surgical anesthesia**- Both local and general anesthesia involve risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia or sedation
- h) **Nerve injury**- Motor and sensory nerves may be injured during an operation. Weakness or loss of movements may occur after surgery and could result in temporary or permanent double vision. Nerve injuries may cause temporary or permanent loss of movements and feeling. Such injuries may improve over time. Injury to sensory nerves may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.
- i) **Chronic pain**- Chronic pain is a very rare complication after surgery.
- j) **Unsatisfactory result**- There is the possibility of a poor result from the surgery. This would include risks such as unacceptable visual acuity, loss of movement, wound disruption, and loss of sensation. You may be disappointed with the results of surgery. It may be necessary to perform additional surgery to improve your results.
- k) **Allergic reactions**- In rare cases, local allergies to tape, suture material, or topical preparations have been reported. Systemic reactions which are more serious may occur to drugs used during surgery and prescription medicines. Allergic reactions may require additional treatment.
- l) **Delayed healing** - Wound disruption or delayed wound healing is possible. Some areas may not heal normally or may take a long time to heal. Specifically, the cornea is exquisitely sensitive to the energy required to break up the cataract. It may react by swelling or decompensating leading to decreased vision. It may necessitate additional treatment(s) up to and including corneal transplantation. It may never recover fully.
- m) **Long term effects / additional surgery necessary** - The practice of medicine and surgery is not an exact science. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with surgery. Other complications and risks can occur but are even less common. There are many variable conditions in addition to the above risks and potential surgical complications that may influence the long term result from surgery. In some cases, complications may occur weeks, months, or even years later. Subsequent decreases in vision may occur as the result of aging or other circumstances not related to surgery and may result in poor vision, total loss of vision, or even loss of the eye in rare situations. Future surgery or other



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treatments may be necessary to maintain the results of any operation. You may need additional treatment or surgery to treat complications.

i) **Specifically, the posterior capsule** may opacify necessitating a “YAG laser posterior capsulotomy”. The capsule is the shell of the natural lens left behind to hold the implant. Think of this as “Saran wrap” that become “wax paper” and interferes with the passage of light through the implant. The “YAG” laser is used to “punch” a hole in the wax paper so that light may pass through the implant unobstructed providing a clearer image and reducing glare. This and any other additional treatment(s) is/are not included in the fee for this procedure.

3) **WHAT IS POSTERIOR CAPSULAR OPACIFICATION (PCO) AND HOW IS IT TREATED?**

- a) The human lens is similar to an onion, an M&M, a grape, or an orange in that it has a shell (called the “Capsule”) and a center, with several layers in between. During cataract surgery, the cloudy layers are removed through an opening in the front of the shell or “Capsule”, but the back of the capsule is typically left in place. Light rays passing through the implant or intraocular lens (“IOL”) also pass through the posterior capsule since the IOL is typically placed within this capsule.
- b) Over time, the posterior capsule may opacify or cloud up. This hazy capsule scatters incoming light rays causing blurry vision, halos, glare, and other visual disturbances.
- c) Fortunately, there is a relatively safe, simple, and painless laser procedure (YAG PC) that can clear the central portion of the posterior capsule, allowing light to pass clearly through the implant improving the clarity of vision and reducing or eliminating the image distortion, glare, and halos.

4) **FINANCIAL RESPONSIBILITIES**

- a) The cost of surgery involves several charges for the services provided. The total includes fees charged by your doctor, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revisionary surgery would also be your responsibility.

5) **DISCLAIMER**

- a) Informed-consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed-consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

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Page 3 of 5



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- b) However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your surgeon may provide you with additional or different information which is based on all the facts in your particular case and the state of medical knowledge.
- c) Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. d) It is important that you read the above information carefully and have all of your questions answered before signing the consent on the next page

6) DISCONTINUING ANTICOAGULANTS

- a) Anticoagulants are typically not an issue with this procedure.

7) AFFIRMATION & PATIENT’S ACCEPTANCE OF RISKS

- a) I acknowledge that my doctor has explained this operation, procedure, test, service or treatment to me in terms that I understand. In addition, my doctor has explained to me, to my satisfaction, the significant risks, benefits, alternatives (including no surgery), and risks of alternatives of the proposed operation or procedure, and the significant risks if I do not have this operation. I understand that it is impossible for the doctor to inform me of every possible complication that may occur. By signing below, I agree that my doctor has answered all of my questions, that I have been offered a copy of this consent form, and that I understand and accept the risks, benefits, and alternatives of cataract surgery. I have checked my choice for astigmatism correction and type of IOL.

CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

- 1) I hereby authorize David M. Mills, MD, FACS and any such assistant(s) as may be selected to perform the following procedure or treatment:

a) YAG Laser Posterior Capsulotomy

- 2) I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun
- 3) I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve(s) risk and the possibility of complications, injury, and sometimes death.
- 4) I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
- 5) I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

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Page 4 of 5



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- 6) For purposes of advancing medical education, I consent to the admittance of observers to the operating room.
- 7) I consent to the disposal of any tissue, medical devices or body parts which may be removed.
- 8) Further, I authorize the above physician and/or his agent(s) to preserve for scientific or educational purposes or for use as grafts in living persons, or to otherwise dispose of any organs, tissues, limbs or other body parts surgically removed in accordance with customary medical practice. I further relinquish any right in or to any tissue, organ or graft removed from my person.
- 9) I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.
- 10) The above information has been explained to me in a way I understand and as completely as possible, to my satisfaction.
- 11) I understand that there are options available to the proposed treatment including the option to do nothing.
- 12) I accept the well-known, common and uncommon risks of this procedure and I consent to the performance of the described procedure.

I CONSENT TO THE TREATMENT OR PROCEDURE:

Patient Signature: _____ Date: _____
 Witness Signature: _____ Date: _____

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