Preparing for your Cataract Evaluation

Welcome
Thank you for trusting our team with your cataract evaluation. Our goal is to help every patient achieve their highest level of vision.

Preparing for your appointment
- Please bring a driver since your eyes will be dilated.
- The exam usually requires 2-3 hours.
- If surgery is recommended, the surgery is on a different date than your exam.
- Bring your glasses, a list of current medications and any contact lens information.
- Wear your contact lenses. If surgery is recommended, contact lenses are discontinued and additional implant measurements taken several weeks later.

Important Considerations
- If a decision is made to have surgery, please rest assured that cataract surgery is one of the most common and safest operations performed. The majority of patients see much better after surgery. Our surgical facility is AAAHC certified and dedicated to eye surgery only. Many of our team have assisted with thousands of eye procedures providing a wealth of talent and experience.
- Our practice has the most advanced technology available for cataract surgery. We offer LenSx laser assisted cataract surgery and ORA intraoperative aberrometry for the most precise surgery and implant selection possible.
- Vision is restored with an intraocular lens implant and glasses.
- All patients receive the highest quality modern implants that are FDA approved and expected to last a lifetime.

Customized Surgery
- Patients can now choose between traditional cataract surgery or advanced technology Laser Cataract Surgery with ORA imaging. Traditional cataract surgery is typically covered by medical insurance subject to deductible and copay. The custom upgrades have additional out of pocket expense that we keep as low as possible in order to make this technology available for our patients.
- Studies show both traditional and laser surgical techniques give excellent results.
- Please review the attachments before your exam. This information helps start the conversation regarding your specific visual needs and goals. If you are not sure, we will guide you through the evaluation process and make recommendations.

We look forward to serving you.
Visual Functioning Questionnaire

To help us evaluate your level of visual functioning it is important to know the problems you are having as you go through your daily activities.

Please circle answer YES or NO

Does your sight make it a problem for you to:

Read newspapers or telephone books       YES     NO
See traffic signs or store aisle directories    YES     NO
Read your letter and bills            YES     NO
Read price tags or medicine labels       YES     NO
Recognize people's faces              YES     NO
See stair steps or curbs              YES     NO
See TV clearly                        YES     NO
Manage your home                      YES     NO
Do your favorite hobby                YES     NO
Enjoy recreation and leisure          YES     NO

Are you bothered by:

Headlight glare from cars              YES     NO
Halos around light at night            YES     NO
Glare from glossy magazines            YES     NO
Bright sunlight when outside           YES     NO
Facing windows with bright daylight    YES     NO
Hazy, foggy or blurry vision          YES     NO

If stronger glasses won't improve your vision anymore and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?       YES     NO

Patient Name (print): ___________________________ Date: __________
Patient Signature: _____________________________
Physicians Signature: _________________________
"We are very proud to offer patients the latest and most advanced technology for cataract surgery.

**LenSx Femtosecond Laser** for a more precise, gentler cataract procedure.

**ORA intraoperative imaging** for more precise implant selection and astigmatism management.

Berg Eye Group is the first practice in our region, the second in Georgia and one of a few in the Southeastern United States to offer the combination of **LenSx femtosecond cataract laser** and **ORA technology** to patients having cataract surgery! Using this advanced technology we offer more precision in the key steps of cataract surgery, selection of intraocular lens implant and treatment of astigmatism that ever before.

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**Vision without glasses after Cataract Surgery**

**Traditional or standard technique:** 60% of Patients see 20/30 or better without glasses.

**ORA guided implant and astigmatism management:** 80% of patients see 20/30 or better.

**LenSx femtosecond cataract laser** combined with **ORA System.** 92% see 20/30 or better.

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![20/30 or Better Without Glasses](chart.png)

**ORA** = (Optimized Refractive Analysis)  
http://oraguied.com/  
Bergeye.com
# Cataract Surgery Options

<table>
<thead>
<tr>
<th>Standard Cataract Surgery</th>
<th>Laser Refractive Cataract Surgery Upgrades</th>
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</thead>
<tbody>
<tr>
<td>For patients who don’t mind wearing glasses for all activities.</td>
<td>For patients who want the most advanced technology available and for patients who want the greatest chance of seeing without glasses. LenSx laser for three key surgical steps, ORA wavescan for precise evaluation of astigmatism and implant power.</td>
</tr>
<tr>
<td>Standard insurance covered surgery that does not include LenSx laser surgery, ORA intraoperative imaging, specialized preop imaging, astigmatism management or postop enhancements.</td>
<td>LenSx with ORA Package: 90% see 20/30 without glasses at their selected distance compared to Standard Surgery: 60% see 20/30 without glasses at their selected distance.</td>
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<td></td>
<td>Upgrade fees include the additional testing and procedures to give the best chance of seeing without glasses at your selected distance. Additional fee $1,650 — $2,650 per eye. Fees also include postop enhancements for up to one year.</td>
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<tr>
<td>Single Vision Implant</td>
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<tr>
<td>Single vision Implant selected for far or near.</td>
<td>Single Vision Implant with astigmatism management and imaging</td>
</tr>
<tr>
<td>Single vision Implant selected for far, intermediate or near.</td>
<td>Treatment of low to moderate amounts of astigmatism by incisional or LenSx laser technique.</td>
</tr>
<tr>
<td>60% see 20/30 or better without glasses at one distance.</td>
<td>Single vision Implant selected for far, intermediate or near.</td>
</tr>
<tr>
<td>Most patients require bifocals.</td>
<td>90% see 20/30 or better without glasses at one distance.</td>
</tr>
<tr>
<td>Surgical enhancements available after surgery at regular fees.</td>
<td>A common outcome is glasses to “fine tune” your far vision and bifocals or reading glasses for near vision.</td>
</tr>
<tr>
<td></td>
<td>Recommended for most patients and those wanting to target a specific prescription including monovision or blended vision.</td>
</tr>
</tbody>
</table>
Permission to perform non-covered Cataract Pretesting

Patient's Name:

NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

We recommend the screening tests listed below for patients considering cataract surgery. These tests give valuable information to assist with recommending the best procedure and selecting the best implant for your surgery. These tests are covered when performed to treat disease but are often considered medically unnecessary when performed to screen for disease. If these tests are not a covered benefit and consequently your health plan will not pay for them, the patient is responsible for payment.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these services, knowing that you may have to pay for them yourself.

The tests recommended are:
1. Corneal Topography –
2. Laser Retinal Scan for Macular Disease

You are responsible for all of the fees associated with a non-covered service. The charge for the surgeon’s professional fee is $165.00

<table>
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<tr>
<th>Beneficiary Agreement</th>
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<tbody>
<tr>
<td>Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of patient or person acting on patient’s behalf</th>
<th>Date</th>
</tr>
</thead>
</table>
Permission to perform Non-Medicare covered Cataract Pretesting

Patient Name: ___________________________  Identification Number: ___________________________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn’t pay for the items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

<table>
<thead>
<tr>
<th>Items or Services</th>
<th>Reason Medicare May Not Pay</th>
<th>Estimated Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening tests for Corneal and Macular disease.</td>
<td>The Medicare law, Social Security Act §1862(a)(1)(A), does not cover these services when performed to screen for disease. These tests give important information for planning cataract surgery.</td>
<td>$75.00 $90.00</td>
</tr>
<tr>
<td>1. Corneal Topography,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Laser Retinal Scan for Macular Disease</td>
<td></td>
<td></td>
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</table>

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the _____________________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS:  
Check only one box. We cannot choose a box for you.

[ ] OPTION 1. I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

[ ] OPTION 2. I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and I cannot appeal if Medicare is not billed.

[ ] OPTION 3. I don’t want the items or services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: ___________________________  Date: ___________________________

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
This checklist will assist us in providing the treatment best suited for your visual needs if it is determined that cataract surgery is appropriate for you. It is important that you understand that many patients still need to wear glasses for some activities after surgery but due to recent technological advances, we are now able to offer the possibility for you to be potentially free from glasses. Please fill this form out completely and return it to us. If you have any questions, please let me know and we will be happy to assist you.

1. Are you interested in seeing well at distance without glasses after surgery?
   ___ I prefer no distance glasses
   ___ Not important to me. I would not mind wearing distance glasses.

2. Are you interested in seeing well at near without glasses?
   ___ I prefer no reading glasses
   ___ Not important to me. I would not mind wearing reading glasses.

3. How important is seeing without glasses?
   Very important___ Important___ Somewhat important___ Not important___

For Questions 4 and 5, please refer to the chart below:

<table>
<thead>
<tr>
<th>ZONE 1</th>
<th>ZONE 2</th>
<th>ZONE 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Shaving</td>
<td>Watching TV/ Movies</td>
</tr>
<tr>
<td>Sewing</td>
<td>Computer Use</td>
<td>Driving/ Road Signs</td>
</tr>
<tr>
<td>Applying Make-up</td>
<td>Cooking</td>
<td>Golfing</td>
</tr>
<tr>
<td>Needle point/sewing</td>
<td>Reading Labels on Shelf</td>
<td>Boating</td>
</tr>
<tr>
<td>Painting</td>
<td>Cleaning</td>
<td></td>
</tr>
<tr>
<td>Menus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Which “Zone of Vision” is most important to you? Please choose one of the following 3 options:
   ___ Zone 1    ___ Zone 2    ___ Zone 3

5. If you had to wear glasses after surgery for one zone, for which zone would you be most willing to use glasses?
   ___ Zone 1    ___ Zone 2    ___ Zone 3

6. If you could finance the cataract correction, would you be interested in hearing more information on financing options?
   ___ Yes     ___ No

7. How often do you drive at night?
   ___ Never (0 X wk) ___ Seldom (1-2 X wk) ___ Occasionally (3-4 X wk) ___ Frequently (>4 times/wk)

8. Have you ever successfully worn a contact lens for Monovision?
   ___ Yes     ___ No

9. Please tell about other quality of life vision concerns that you have: (i.e. golf, tennis, reading, knitting, playing cards, etc.)

   Easy Going ★ __________________________________________ ★ Perfectionist