



Dear Patient,

Your eye doctor has informed you that you have a cataract in one or both of your eyes and is referring you to McDonald Eye Associates for an evaluation and possible scheduling for cataract surgery.

Your eye doctor will make the appointment for you to visit us. Please take the time to review the enclosed information, as we feel this will be most helpful to you in preparation of your visit to our clinic.

When you arrive, there will be a thorough examination of your eyes. The exam will take a couple of hours, so please plan accordingly. We will need to dilate your eyes, which will require you to have someone to drive you home.

Once your examination is finished, you may choose to proceed with scheduling your surgery. One of our cataract surgery coordinators will meet with you and set a date and time for the procedure. They will tell you where to go for the surgery, what time to arrive, and will answer any questions regarding medications and insurance.

Having eye surgery is a very important decision, and at McDonald Eye Associates, we do not take it lightly. We hope to answer all of your questions by the end of your visit and put you at ease with the decision you've made.

Enclosed please find some forms to fill out prior to your visit with us. One form asks several questions about your vision, which will be helpful to us in understanding your vision problems. All other questions will be answered during your visit.

Thank you for trusting McDonald Eye Associates with the care of your eyes.

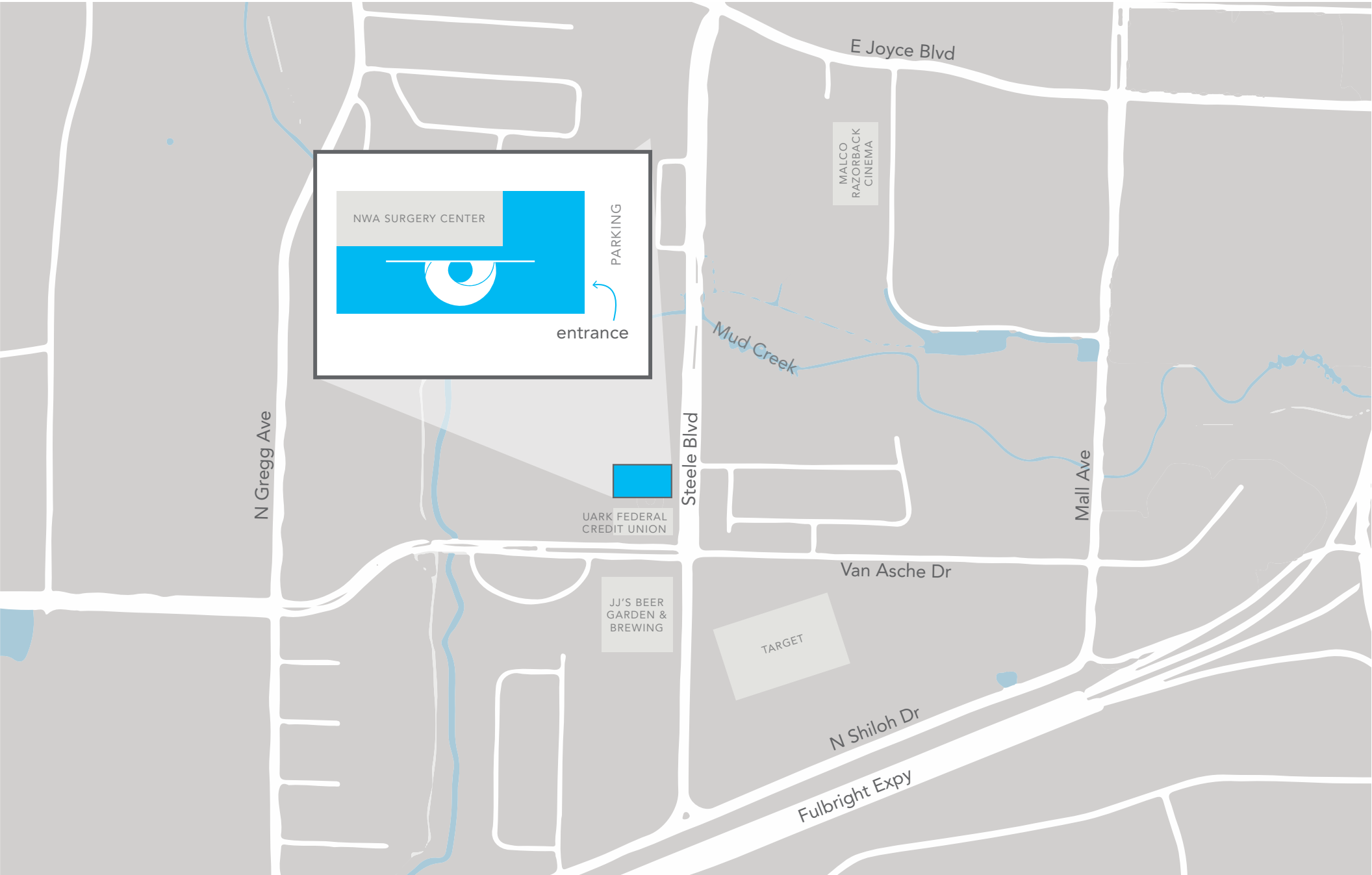
Sincerely,

The Doctors and Staff of McDonald Eye Associates

McDonald Eye Associates



NWA SURGERY CENTER



NWA SURGERY CENTER

PARKING

entrance

E Joyce Blvd

MALCO
RAZORBAK
CINEMA

Mud Creek

N Gregg Ave

Steele Blvd

UARK FEDERAL
CREDIT UNION

Mall Ave

Van Asche Dr

JJ'S BEER
GARDEN &
BREWING

TARGET

N Shiloh Dr

Fulbright Expy



PATIENT CHECKLIST

Please read and fill out the enclosed forms and bring with you to your appointment with McDonald Eye Associates.

1. _____ Read enclosed letter

2. _____ Complete the remainder of the patient information sheet

3. _____ Answer the medical history questionnaire

4. _____ Answer the vision questionnaire

5. _____ Make a list of questions you have for the doctor

6. _____ Please bring your insurance card with you to your appointment

If you have questions that you would like to discuss BEFORE your appointment, please call us at 479-521-2555 or 1-800-262-4405.



Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. McDonald Eye Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information maybe disclosed or used for treatment, payment or health care operations.
- McDonald Eye Associates has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- McDonald Eye Associates reserves the right to change the notice of privacy policies.
- The patient has the right to restrict the uses of their information but McDonald Eye Associates does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- McDonald Eye Associates may condition treatment upon the execution of this consent.

This consent was signed by _____
Printed Name - Patient or Representative

Signature - Patient or Representative

Relationship to Patient (if other than patient) _____

Date _____

In front of: _____
Printed name - Practice Representative



Name: _____

DOB: _____

I understand that professional fees are due and payable at the time of treatment, unless prior arrangements have been specifically made. In case my account is placed for collection, I agree to pay all collection costs and expenses incurred, including reasonable attorney fees. Patients who do not show up for their appointment and do not notify McDonald Eye of cancellation may be subject to a \$25 no-show fee.

I request that payment of authorized insurance benefits be made either to me, or on my behalf, to McDonald Eye Associates for any services furnished by that provider. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize McDonald Eye Associates, in its discretion, to disclose by fax or mail any or all of the information in my medical records to any other health care provider involved in a plan of treatment for me, as well as any person, corporation, or agency which is or may be liable for all or part of McDonald Eye Associates charge, or who may be responsible for determining the necessity, appropriateness, amount or other matter related to McDonald Eye Associates treatment or charge, including, but not limited to insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers.

I authorize release of my previous records to McDonald Eye Associates.

Patient/Guardian Signature

Date _____

Release of Protected Information

I authorize the following to receive information regarding my protected health care information.

Name Relationship Date

Name Relationship Date

Name Relationship Date



YOUR MEDICAL HISTORY

Patient name: _____

Please list any medications or food that you are allergic to:

_____	_____
_____	_____
_____	_____
_____	_____

List the current medications and dosage that you are taking:

_____	_____
_____	_____
_____	_____
_____	_____

Do you use any tobacco products? _____

If so, what type of tobacco products do you use and how often? _____

Do you use any alcohol products? _____

If so, how often? _____

Please circle all medical problems you have or have had:

Arthritis

Asthma

Bleeding tendency

Cancer (type) _____

Chronic Obstructive Pulmonary Disease (COPD)

Congestive Heart Failure (CHF)

Diabetes

Emphysema

Heart disease

High blood pressure

High cholesterol

Hypoglycemia

Lupus

Mitro Valve

Prostate trouble

Seizure disorder

Shortness of breath

Stroke

Thyroid trouble

Ulcers

Please circle all surgeries you have had:

Adenoids
Angioplasty
Appendectomy
Back surgery
Bladder surgery
Caesarian surgery
Cancer surgery (type) _____
Carotid artery
Carpal tunnel
Colon surgery
Ear surgery
Eye surgery (type) _____
Face lift
Gallbladder
Heart bypass
Hemorrhoidectomy

Hernia repair
Hip replacement
Hysterectomy
Kidney surgery
Knee replacement
Lumpectomy
Lung surgery
Mastectomy
Ovaries removed
Pacemaker
Prostate surgery
Thyroidectomy
Tonsillectomy
Tubal ligation
Vasectomy
Other _____

FAMILY MEDICAL HISTORY

Please circle all medical problems any blood relative has or has had:

Arthritis
Blindness
Cancer (type) _____
Cataracts
Crossed Eyes
Diabetes

Glaucoma
Heart problems
High blood pressure
Retinal detachment
Thyroid problems
Other _____

Thank you for taking the time to answer these questions for us. Please use the space below to list any questions you may have.



CATARACT AND REFRACTIVE LENS EXCHANGE QUESTIONNAIRE

The term “cataract” refers to a cloudy lens within the eye. When a cataract is removed, it is replaced with an artificial lens. Some clear lenses that have not yet developed cataracts are removed to reduce or eliminate the need for glasses. If surgery is appropriate for you, this questionnaire will help us provide the best treatment for your visual needs. It is important to understand that many patients still need glasses for some activities after surgery. Please fill this form out completely. If you have questions, please let us know and we will assist you with this form.

1. After surgery, would you be interested in seeing well **without glasses** in the following situations?

Distance Vision (driving, golf, tennis, other sports, watching TV)

I prefer no Distance glasses. I wouldn't mind wearing Distance glasses.

Mid-range Vision (computer, menus, price tags, cooking, board games, items on a shelf)

I prefer no Mid-range glasses. I wouldn't mind wearing Mid-range glasses.

Near Vision (reading books, smartphones, tablets, e-readers, sewing, detailed handwork)

I prefer no Near glasses. I wouldn't mind wearing Near glasses.

2. Please check the **single** statement that best describes you in terms of **night vision**:

a. Night vision is extremely important to me, and I require the best possible quality night vision.

b. I want to be able to drive comfortably at night, but I would tolerate some slight imperfections.

c. Night vision is not particularly important to me.

3. If you **had** to wear glasses after surgery for one activity, for which activity would you be **most** willing to use glasses?

Distance Vision **Mid-range Vision** **Near Vision**

4. Some people prefer to hold their reading material very close, while others prefer holding their reading material much farther away, in their laps. The length of this sheet of paper from top to bottom is 11 inches. Using this sheet of paper as a very rough ruler, try to **estimate approximately** how far from your face you prefer to hold your reading material. Please place an “X” on the following scale to provide a very rough estimate as best you can:

11 inches ----- 16.5 inches ----- 22 inches
 (1 paper length) (1 and a half paper lengths) (2 paper lengths)

5. If you could have **good Distance, Mid-range, and Near Vision all without glasses**, but the compromise was that you might see some **halos, rings, or starbursts** around lights at night, would you like that option? Yes No

6. If you could have **good Distance and Mid-range Vision without glasses**, but the compromise was that you might need glasses for the finest print at **near**, would you like that option? Y N

7. If you have a cataract and would like to reduce or eliminate the need for glasses, insurance may cover a significant portion of your overall procedure cost. Would you be interested in learning more about this option?
 Yes No Maybe, it depends on how much is covered by insurance

8. Please place an “X” on the following scale to describe your personality as best you can:

[-----|-----]
 Easy Going Perfectionist

Please Sign Here _____



VISION QUESTIONNAIRE

In order to help us better understand the problems you may be having due to your vision, please answer the following questions prior to your appointment at McDonald Eye Associates.

Due to your vision, are you currently having problems with: (mark once each line)

	Always	Sometimes	Rarely	Never
Glare or starbursts around lights at night?	_____	_____	_____	_____
Decreased night time vision?	_____	_____	_____	_____
Seeing rings or halos around car headlights?	_____	_____	_____	_____
Hazy, filmy, or blurry vision?	_____	_____	_____	_____
Difficulty reading in dim lighting?	_____	_____	_____	_____
Are you concerned about falling?	_____	_____	_____	_____
Feeling that poor vision has decreased your independence?	_____	_____	_____	_____

ARE YOU ABLE TO:

Read newspapers, phone books, etc.?	_____	_____	_____	_____
Recognize people across a parking lot?	_____	_____	_____	_____

DO YOU HAVE TROUBLE:

Seeing curbs or steps?	_____	_____	_____	_____
Reading traffic signs before you go by them?	_____	_____	_____	_____
Attending church or other social activities at night?	_____	_____	_____	_____
With car headlights blinding you?	_____	_____	_____	_____
Doing hobbies you once enjoyed?	_____	_____	_____	_____
Driving while facing the sun?	_____	_____	_____	_____
Reading labels on jars or cans when shopping?	_____	_____	_____	_____

Do you find yourself frequently cleaning your glasses, because it seems that you are looking through a film?	_____	_____	_____	_____
--	-------	-------	-------	-------

Patient Signature _____

Date _____

McDonald Eye Associates



Dr. Chad Betts, M.D., R.Ph. & Dr. Eddie Mengarelli, M.D.

Cataract Lens Options

- ❑ Standard non-refractive
 - generally covered by insurance
 - One point of vision- generally distance.
 - Expect to be in glasses full time.
- ❑ Continuous Vision / Monovision
 - \$775 per eye without astigmatism & 2200 per eye with astigmatism
 - Two points of vision
 - dominant eye set to distance, non-dominant set to near
 - May need readers to help with fine print
- ❑ Astigmatism correction with a Toric Lens
 - \$2200 per eye
 - One point of vision- generally distance
 - Corrects astigmatism
 - Expect to be in glasses for computer work and reading
- ❑ Crystalens/Trulign
 - \$2800 per eye
 - Corrects astigmatism
 - Two points of vision- distance and computer
 - Expect to be in glasses for reading
- ❑ Odyssey
 - \$2800 per eye
 - Corrects astigmatism
 - Three points of vision- distance, computer, and reading
 - May need readers for fine print
- ❑ ORA
 - \$500 per eye
 - A scan completed to make sure IOL is properly placed during surgery
 - Included in price for Astigmatism, Crystalens/Trulign, and Odyssey
 - Needed if you have had any kind of LASIK in the past

These prices are for the lens only; other surgery fees may apply

3689 N. Steele Blvd
Fayetteville, AR 72703
Phone: 479.521.2555
Fax: 479.521.6761

318 S 52nd Street
Rogers, AR 72758
Phone: 479.464.9702
Fax: 479.464.9706



Using artificial tears before cataract surgery is important because it helps to stabilize the ocular surface (the front of the eye), ensuring accurate pre-operative measurements for the intraocular lens (IOL) and potentially leading to better vision outcomes after surgery by mitigating the effects of dry eye syndrome. Not using them prior to your pre op visit may result in additional visits prior to your surgery date for re-measurements.

Here are a few brands we recommend;

- Refresh Classic
- Refresh Relieva
- Refresh Optive Mega 3
- Refresh Plus
- Systane Ultra
- Systane Complete