



**Florida Doctors Insurance Company
Healthcare Facility Professional Liability
Laser Refractive Procedure Supplement**

The supplement is not a complete application for insurance. It must be submitted in conjunction with Florida Doctors Insurance Company's Healthcare Facility Professional Liability Insurance Application and all other required information.

Facility Name: _____

The data provided should be projected for the 12 months to be covered under the policy.

Type of Service Provided	# Surgeries / Procedures
Radial Keratotomy (RK)	
Astigmatic Keratotomy (AK) / Limbal Relaxing Incisions (LRI)	
Automated Lamellar Keratoplasty (ALK)	
Photorefractive Keratotomy (PRK)	
Laser Assisted In-Situ Keratomileusis (LASIK)	
Laser Epithelial Keratomileusis (LASEK)	
Epi-LASIK	
Bladeless or "All Laser" LASIK	
Intacs Corneal Inserts or Implants (Intacs)	
Laser Thermal Keratoplasty (LTK)	
Conductive Keratoplasty (CK)	
Implantable Lenses (Phakic IOLs)	
Refractive Lens Exchange (RLE) / Clear Lens Extraction	
Other (describe):	

PRE-OP EVALUATIONS

Who conducts the pre-operative evaluations? (Check all that apply)

Surgeon Surgeon's non-physician staff ASC staff Referring Optometrist

Other (describe): _____

INFORMED CONSENT

Who conducts the discussion of informed consent with the patient?

Surgeon Surgeon's non-physician staff ASC staff Referring Optometrist

Other (describe): _____

When is the discussion held? Prior to the day of surgery On the day of surgery

Please submit copies of all informed consent forms related to the Laser Refractive procedures.

POST-OPERATIVE CARE MANAGEMENT

Who performs the first post-operative visit? _____

When does the first visit occur? _____

For how long are patients followed? _____

Describe any co-management process in place and provide all documentation and consent forms utilized.

PHYSICIANS PERFORMING LASER REFRACTIVE PROCEDURES (continue on additional sheet if necessary)

Submit a Certificate of Insurance or a copy of an insurance policy Declarations page showing insurance carrier, policy term, limit of liability (incident and aggregate), retroactive date and any other special provisions for each physician listed below.

Physician Name	American Board Certified or Eligible (Y/N)?	# Laser Refractive Procedures Performed in prior 12 months	
		at all practice locations	at this facility

SUPPLEMENTAL WAIVER AND RELEASE

As authorized representative for the facility, I hereby acknowledge that the foregoing information constitutes a part of my application for insurance with Florida Doctors Insurance Company (FLDIC). If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. If it is determined that I failed or refused to disclose any relevant fact or information or misled, defrauded or lied to FLDIC, I understand that the policy shall be null and void. However, unintentional errors or omissions do not affect my rights under the policy, if issued. I understand that no insurance will be afforded unless and until a complete application is accepted by FLDIC and the facility is notified of said acceptance.

Signature of Authorized Representative

Date

Printed Name of Authorized Representative

Title of Authorized Representative

This application form duly completed together with any supplementary information must be signed in ink by an authorized representative of the applicant. A signature on the form does not bind the applicant or FLDIC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

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