COVID -19 Pandemic and Essential Eye Exam and Treatment Consent Form

Patient Name: _____ Date of Birth: _____ Date: _____

Please read the following statements and initial next to each one to indicate your agreement. If you cannot positively affirm to all of these questions, you will be asked to postpone or reschedule your visit to a later date.

_____ Neither I, nor anyone else that I live with or associate with has been diagnosed with the COVID-19 virus within the past 14 days.

_____ Neither I, nor anyone else that I live with or associate with has travelled outside of the State within the past 14 days.

_____ Neither I, nor anyone else that I live with or associate with has had close contact with anyone who has been outside of the United States within the past 14 days.

_____ Neither I, nor anyone else that I live with or associate with has been directed to quarantine, isolate, or self-monitor at home for the COVID-19 virus by any doctor, hospital or health agency within the past 14 days.

_____ If I have been ill within the past 14 days, I have not had any fever within the past 3 days (72 hours) without the use of fever-reducing medications and it has been at least 7 days since symptoms first appeared.

I acknowledge and agree to immediately notify [the Practice] (the "Practice") of any change in circumstances that should render any of the above representations untrue or false within five (5) days after my visit to the Practice.

I have answered the questions above honestly and to the best of my knowledge. I understand that the Practice, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to completely eliminate potential exposure.

By signing this form below, I agree that I will not hold the Practice or any of its doctors or staff personally responsible should I, or someone I came in contact with, becomes positive or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and hold harmless the Practice and its doctors and staff for injury, loss or damage arising out of my visit. I understand that the COVID-19 virus can lead to illness, disability, or even death and I knowingly take the risk of exposure as I deem my exam to be essential to the maintenance of my vision.

_____	_____	_____
PRINT LEGAL NAME	SIGNATURE	DATE