COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: _____ DOB: _____

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

_____ I have not, nor has anyone in my immediate household, been diagnosed with COVID-19, had a fever, cough, difficulty breathing, or cold/flu-like symptoms in the last 2 weeks.

_____ I am not, nor is anyone in my immediate household, currently providing care for anyone who has been diagnosed with COVID-19, had a fever, cough, difficulty breathing, or cold/flu-like symptoms in the last 2 weeks.

_____ I am not, nor is anyone in my immediate household, currently under voluntary or involuntary quarantine.

_____ I have not, nor has anyone in my immediate household, been under voluntary or involuntary quarantine in the last 2 weeks.

_____ I have not, nor has anyone in my immediate household, traveled internationally to any of the following countries in the last 2 weeks: China, Iran, Italy, Japan, or South Korea.

We are working hard to insure the health and safety of our patients and staff. We are limiting the number of patients in the office to conform to strict social distancing guidelines. Additionally, we are performing careful sanitation of all areas which each patient interacts with following every patient encounter. Despite our best efforts, we cannot guarantee a perfectly sterile environment.

By signing this form below, I agree that I will not hold Family Eye Doctors or any of its doctors or staff personally responsible should I, or someone I come in contact with, become 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 discharge Family Eye Doctors and its doctors and staff for injury, loss, or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____	_____	_____
Print Legal Name	Signature	Date