COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: _____ DOB: _____ Date: _____

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

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 (thirty) days.

On March 16, 2020, The Centers for Disease Control and Prevention (CDC) issued the following Public Health Reminder:
Healthcare facilities and clinicians should prioritize urgent and emergency visits and procedures now and for the coming several weeks. The following actions can preserve staff, personal protective equipment, and patient care supplies; ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic:

Delay all elective ambulatory provider visits
Reschedule elective and non-urgent admissions
Delay inpatient and outpatient elective surgical and procedural cases
Postpone routine dental and eyecare visits

I have read the above stated Public Health Reminder and have answered the health questions honestly and to the best of my knowledge. I understand that Eyes on Sunrise, 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 eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Eyes on Sunrise 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 Eyes on Sunrise and its doctors and staff for injury, loss or damage arising out of my visit. I understand that the 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