COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: ______________________________ DOB: ____________ Today's Date: ____________

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 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 a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.

___ Neither I, nor anyone living in my immediate household, have traveled outside of the state of California in the last 30 days.

I understand that Professional Visioncare Associates (PVA), 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. Based upon CDC guidelines, I am aware that PVA has implemented the following precautions: upon arrival, temperature and oxygen levels will be checked, facemasks must be worn to enter, and frequent hand washing for 20 seconds is essential.

By signing this form below, I acknowledge that I have answered the health questions above honestly and to the best of my knowledge. I agree that I will not hold Professional Visioncare Associates or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positively or presumptively positively diagnosed with COVID-19 virus. There are certain inherent risks associated with an eye exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge PVA 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 I knowingly take the risk of exposure as I choose to attend to my eye care at this time and under these above referenced conditions.

______________________________ ______________________________ ____________________

PRINT LEGAL NAME SIGNATURE DATE