Family Optometric Associates P.C.

COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

_____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.

_____Neither I, nor anyone living in my immediate household, have traveled outside of the state in the last 14 days.

I have answered the health questions above honestly and to the best of my knowledge. I understand that Family Optometric Associates, P.C., 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 Family Optometric Associates, P.C., its doctors, or staff responsible should I, or someone I come in contact with, become positive or presumptive 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 Optometric Associates, P.C. 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.

_____

Patient(s) Name Printed:

_____

Patient/Guardian Signature:

Date: _____