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 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
(initial here) 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
(initial here) who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 (thirty) days.

I have read and have answered the health questions above honestly and to the best of my knowledge. I understand that *CE Eye Care*, 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 *CE Eye Care* or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive 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 *CE Eye Care* 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