EYEDENTITY

COVID-19 Pandemic Eye Exam and Treatment Consent

Please read and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all of these questions, we ask that you reschedule your visit to a later date.

______ I do not currently, nor have I had in the last two (2) weeks, a fever, cough, sore throat, loss of smell/taste or other symptoms associated with illness.

______ 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 thirty (30) days.

______ Neither I, nor anyone living in my immediate household, have traveled outside of the United States in the last thirty (30) days.

I have read the above and have answered honestly and to the best of my knowledge. I understand that EYEDENTITY, Dr. Atkins, and all team members 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 below, I agree that I will not hold EYEDENTITY, Dr. Atkins, or any team members personally responsible should I, or someone I come in contact with, become positive or presumptively positively diagnosed with the COVID-19 virus. If I am diagnosed, I agree to let EYEDENTITY know right away. 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 EYEDENTITY, Dr, Atkins, and all team members for injury, illness, 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 eye health and vision.

Signed: ___________________________ Dated:_____________