ANDERSON EYECARE

COVID-19 Pandemic Eye Exam and Treatment Consent

Drs. John and Terri Anderson

Patient Name:_____Date of Birth:_____ Date:_____

Please read the following statements and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all of these questions or decline to wear a mask, 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 (2) weeks, a fever, cough, sore throat, loss of smell/taste or other cold symptoms and I am not awaiting COVID-19 test results.

_____ 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.

_____ Neither I, nor anyone living in my immediate household, have travelled outside of the United States in the last 30 days.

I have read the above and have answered the health questions above honestly and to the best of my knowledge. I understand that Anderson Eyecare, its doctors and 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 this form below, I agree that I will not hold Anderson Eyecare or any of its doctors or team members 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 Anderson Eyecare and its doctors and team members 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

Office Use Only ----------

 Non-Contact Thermometry (Pass = < 100.5) Pass Fail _____