­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.**

\_\_\_\_ 1. I do not currently have, nor have I had in the last two weeks, a fever, chills, cough, sore throat, loss of smell/taste, or other cold/flu symptoms.

\_\_\_\_ 2. 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.

\_\_\_\_ 3. Neither I, nor anyone living in my immediate household, have traveled outside of the state of Texas in the last 30 days.

I understand that there is no definitive way to eliminate potential exposure to the COVID-19 virus by one hundred percent, but that Pflugerville Vision Care, its doctors and staff, are taking every precaution to limit that exposure. By signing this form below, I agree that I will not hold Pflugerville Vision Care 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 the COVID-19 virus. I further release and discharge Pflugerville Vision 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 accept the inherent risks associated with an eye exam during this epidemic.

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Patient Signature Today’s Date

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Printed Name of Person Legally Responsible for Patient’s Medical Decisions (if other than the patient)

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Responsible Party Signature Today’s Date