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MEDICAL & SURGICAL DISEASES OF THE EYE
COMPREHENSIVE OPHTHALMOLOGY
WWW.EYECARESF.COM

COVID-19 Informed Consent

By signing the form below, you acknowledge each of the following statements.

- I understand that I am consenting to a routine appointment ("visit"), elective treatment, procedure, or surgery that is not urgent or emergent.

- I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

- I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that following through with the visit, elective treatment, procedure, or surgery can lead to a higher chance of complication and death.

- I understand that exposure to COVID-19 before, during, and after my routine visit, treatment, procedure, or surgery may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. If I develop symptoms of COVID-19, I may need additional care that may require that I go to an emergency department or hospital.

- I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

- I understand that this visit or elective treatment/procedure/surgery may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the visit/treatment/procedure/surgery.

- I have been given the choice to have my visit, treatment, procedure, or surgery at a later date. I understand the potential risks to my vision & eye health of delaying and want to proceed.

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- I understand that signing this consent form today will provide my written consent to this visit or treatment and all subsequent visits or treatments with my provider(s).
- I have read this consent or someone has read it to me.

Name: _____

Date of Birth: _____

Signature: _____

Today's Date: _____