SUSAN FISHER OD PLLC

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COVID -19 Pandemic and Essential Eye Exam and Treatment Consent Form

Patient's Name: _____ Date of Birth: _____

Please read the following statements and initial next to each one to indicate your agreement**.** If you cannot positively affirm to all of these questions, you may be asked to reschedule your visit to a later date.

_____ Neither the patient, nor anyone else that the patient lives with or associates with**,** has been diagnosed with the COVID-19 virus within the past 14 days.

_____ Neither the patient, nor anyone else that the patient lives with or associates with**,** has travelled outside of New York State within the past 14 days.

_____ Neither the patient, nor anyone else that the patient lives with or associates with**,** has had close contact with anyone who has been outside of the United States within the past 14 days.

_____ Neither the patient, nor anyone else that the patient lives with or associates with**,** has been directed to quarantine, isolate, or self-monitor at home for the COVID-19 virus by any health professional or health agency within the past 14 days.

_____ If the patient has been ill within the past 14 days, the patient:

1. Has not had any fever, nor used any fever reducing medication, within the past 3 days (72 hours), and
2. It has been at least 7 days since any symptoms first appeared.

I agree to immediately notify the "Practice" (Susan Fisher, OD PLLC, and any of her doctors and/or staff) of any change in circumstances that should render any of the above representations untrue or false within five (5) days after the patient's visit to the Practice.

I have answered the questions above honestly and to the best of my knowledge. I understand that the Practice is taking reasonable precautions to limit potential exposure to the COVID-19 virus. I also understand that there is no definitive way to completely eliminate potential exposure.

By signing this form below I agree that I will not hold the Practice responsible should the patient, or someone the patient came in contact with, becomes positive (or presumptively positive) or diagnosed with the COVID-19 virus. I acknowledge that 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 hold harmless the Practice for injury, loss or damage arising out of the visit. I understand that the COVID-19 virus can lead to illness, disability, or even death. I knowingly take the risk of exposure as I deem this exam to be essential to the patient's vision.

_____	_____	_____
Print Legal Name and Relationship to Patient	Signature	Date