PRO VISION EYE CARE CENTER

COVID – 19 Pandemic Essential Exam and Treatment Consent Form

Patient Name: _____ DOB: _____ Date: _____

Temperature Results: _____/_____ Date/Time:_____

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, 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 weeks, a fever, cough, sore throat, loss of smell/taste or other cold symptoms.

_____ 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 in the last 30 (thirty) days.

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

By signing this form below, I agree that I will not hold **Dr. Jesus Cuevas & Dr. Anastasia Jobson** or any of its doctors or staff 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 a medical exam during a pandemic and I assume full responsibility for personal illness that my result and further release and discharge **Dr. Jesus Cuevas & Dr. Anastasia Jobson** 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 take the risk of exposure as I deem my exam to be essential to the maintenance of my vision.

_____ _____ _____

PRINT LEGAL NAME SIGNATURE DATE