The Medical Eye Center

COVID-19 Health Questionnaire and Informed Consent

I acknowledge that I have **NOT** been exposed nor diagnosed with COVID 19 disease in the last 14 days to the best of my knowledge.

I also acknowledge that neither myself or others accompanying me on today's appointment

DO NOT have any of the following symptoms today or within last 14 days

Fever (defined as above 99.6 degrees)

Cough

Shortness of breath and/or trouble breathing

Persistent pain, pressure, or tightness in the chest

a. I understand that if any of the above is applicable to me , then you will be requested to reschedule today's appointment to a later date or consider a televisit.
b. Thank you for your continued trust in our practice. As with the transmission of any communicable disease like cold or flu, you may be exposed to COVID-19 at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. Despite our careful attention to personal barriers, disinfection, there is still very little chance that you could be exposed to an illness in our office, just as you might be at your gym or grocery store. Although we have taken measures to provide social distancing in our practice, due to the nature of our work/procedures we provide, it is not possible to maintain social distancing between the patient, doctor, staff, and sometimes other patients at all times. **Although exposure today is unlikely, do you accept the risk and consent to treatment?**

   _____*Yes* _____*No*

_____ _____

Patient Signature **Date**