Patient Name: DOB: Date:

Please read the following statements and initial next to the statements indicating your agreement. If you cannot positively affirm to all of the statements below, you will be asked to ***postpone*** or ***reschedule*** your visit to a later date. ***Please submit this form to FyEyesOptometric@Yahoo.com***

_____ I *do not* currently, nor have I had in the last two weeks, a fever, cough, sore throat, loss of smell or 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.

_____ I am *not* currently awaiting results of COVID-19 tests.

_____ I will be required to wear a face mask at all time during my appointment. If I don't have one, I will have the option of purchasing one onsite for $5.00, or postpone my appointment to a later date.

_____ Upon entering the office, I will be asked to have my hands washed immediately.

_____ To assure the proper sanitation and disinfection between each patient encounter, I understand that my exam may take up 30-45 minutes ***more*** than usual.

I have read and have answered the health questions above honestly and to the best of my knowledge. I understand that F.Y. Eyes Optometric and its staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by 100%.

By signing this form below, I agree that I will not hold F.Y. Eyes or any of its staff personally responsible should I, or someone I come in contact with, become positive or presumptively positive diagnosed with COVID-19 virus. 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 discharge F.Y. Eyes and its doctor 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 eye exam to be essential to the maintenance of my vision.

_____ _____ _____

Print Legal Name Signature Date