NVISION®
EYE CENTERS

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CORONAVIRUS ATTESTATION & TREATMENT CONSENT

NVISION is committed to the health of our community. With the recent outbreak of Coronavirus we are taking extra measures to protect the health of our patients and employees. Please note that your doctor and staff may wear masks and gloves and may not shake your hand to minimize potential spread of infections.

Patient Attestation Statements

Note: If you cannot positively affirm NO to all these questions,
you may be asked to postpone or reschedule your visit to a later date.

1. Have you had in the last 14 days, a fever, cough, sore throat, loss of smell/taste or other cold symptoms? ☐ Yes ☐ No
2. To the best of your knowledge, have you been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 (thirty) days? ☐ Yes ☐ No

I have read the above and have answered the health questions above honestly and to the best of my knowledge. I understand that NVISION Eye Centers, its doctors, nurses, and 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 one hundred percent.

By signing this form I agree that I will not hold NVISION Eye Centers or any of its doctors, nurses, or staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge NVISION Eye Centers 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. I knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision and I consent to medical treatment.

_____	_____
Printed Patient Name	*Date of Birth*
_____	_____
Signature of patient (if over 18) or patient's parent or legal guardian	Date
_____	_____
If signed by parent/legal guardian, print name	Relationship