CHRYCY EYE GROUP

COVID-19 Pandemic Essential Exam and Treatment Consent Form

Patient Name:_______________________________ DOB: _____________ Date:___________

Please read the following statement and check 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 taste/smell, flu or other cold like 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 days.

By signing this form below, I agree that I will not hold CHRYCY EYE GROUP or any of its doctors or staff personally responsible should I, or someone I come in contact with, becomes positive or presumptively positive diagnosed with the COVID-19 virus. There are certain risks associated with a medical exam during a pandemic and I assume full responsibility for any peronal illnesses that may result. Furthermore, I release and discharge CHRYCY EYE GROUP, its doctors, and staff for injury, loss or damage arising out of my visit. I understand that a COVID-19 infection can lead to illness, disability, or even death and knownly take the risk of exposure as I deem my exam to be essential to the maintaince of my vision.

_______________________________ _______________________________ DATE: _______________

Print Patient Name Patient Signature (Print name if digitally signed)

Help us keep your information up to date.
*If information has not changed, you may skip this step.

Date: ______________________

Name: ____

Date of Birth: ____

Address: ____

City:_______________ State: _________ Zip: _____________

Email Address: ____

Phone Numbers

Home: _________________________

Cell:___________________________

Work: __________________________

*If patient is under the age of 18, please provide us with parent information as well.

Parent Name: ____

Date of birth: ____

Address:____

City: ________________ State: ______________ Zip:_____________

DILATED FUNDUS EXAM

Florida Board of Optometry and the American Optometric Association recommend a dilated eye examination to fully assess the function and health of your eyes. Without dilations, a condition with the potential for the potential for the partial or total loss of vision may exist and go undetected. Dilation is a part of a complete eye examination and does not cost extra.

Dilation will cause sensitivity to light and will make your near vision blurry, temporarily. Our office will provide you with disposable sunglasses to minimize your sensitivity.

Should you have any questions, the Doctor will be happy to answer them.

The doctors prefer a dilated fundus exam but if you do not wish to have this evaluation at this time, please check the box below & sign.

☐ I understand the importance of this exam but I decline at this time.

Signature: ___________________________________

Date: _______________________________________

OPTOMAP RETINAL IMAGING

This additional test allows the Doctor to see a much more detailed view of the retina than is possible with conventional methods. It will help the doctor diagnose ocular diseases such as Cancer, Diabetes, High Blood Pressure & Elevated Cholesterol.

We recommend this test to ALL patients and especially those who would like a more complete retinal, optic nerve, and macular evaluation.

The fee for the OPTOMAP is $39.

Please INITIAL next to your preference below.

__________ Yes, I would like this examination.

__________ No, I would not like this examination/

CONTACT LENS AGREEMENT

In addition to general eye health assessment, the doctor will assess issues related to contacts such as abnormal blood vessel growth, corneal damage, hygiene, discomfort and poor surface compatibility. The **estimated fee** for a standard contact lens evaluation ranges **between $40 to $100**. If you have specialty contact lens needs due to Keratoconus or other medical issues there is a separate fee schedule. These fees will cover any contact lens related follow ups for a 30-day period. These fees are applicable for new and previous users of contact lens. **Services rendered for contact lens evaluation are not included in an eye health evaluation and vision assessment.**

By signing, I acknowledge that I understand the policies regarding the contact lens health evaluation and agree to the associated fees. I understand if my insurance does not cover the fees, I will be responsible for the fee. I understand that these fees are an estimate and are subject to changes based on the doctor's final assessment. I also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage.

Signature: _______________________________________ Date: _______________