

## COVID-19 RISK AWARENESS

I understand that I am consenting to an elective office visit/treatment/procedure/surgery that is not urgent or emergent. I also understand that the coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization, and that COVID-19 is extremely contagious and is believed to spread by person-to-person contact. As a result, federal and state health agencies recommend social distancing.

I understand that my doctor at Plastic Eye Surgery Associates has put in place what are currently believed to be the most up-to-date, reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective office visit/treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my elective office visit/treatment/procedure/surgery could result in any of the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization (up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death).

I understand that COVID-19 may cause additional risks, some of which may not be known at this time, and that after my elective office visit/treatment/procedure/surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that any elective treatment/procedure/surgery in itself may also require additional care, which may require that I go to an emergency department, other specialist, or hospital.

I understand that this elective office visit/treatment/procedure/surgery procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent, I accept that risk and give my permission to proceed with an office visit/treatment/procedure/surgery. I have been given the choice to have my office visit/treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed. I have read this consent, or someone has read it to me.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Houston, TX**  
3730 Kirby Drive, Suite 900  
Houston, TX 77098  
Phone: (713) 795-0705  
Fax: (713) 807-0630

**The Woodlands, TX**  
9180 Pinecroft Drive  
Medical Plaza 4, Suite 250  
Shenandoah, TX 77380  
Phone: (713) 795-0705  
Fax: (713) 807-0630

**Pensacola, FL**  
17 East Main Street, Suite 100  
Pensacola, FL 32502  
Phone: (850) 473-0990  
Fax: (850) 473-0790

**Destin, FL**  
4012 Commons Drive West,  
Suite 110  
Destin, FL 32541  
Phone: (850) 473-0990  
Fax: (850) 473-0790