MACULA RETINA VITREOUS CENTER
SURGICAL AND MEDICAL RETINA

TORRANCE 20528 HAWTHORNE BLVD,
SUITE #201, CA 90503
P: (424) 247-9090 | F: (424) 247-9095

LOS ANGELES 1414 S. GRAND AVE,
SUITE #440, CA 90015
P: (213) 747-9090

COVID-19 Risk Informed Consent

I,_____understand that I am consenting to evaluations and/or futuretreatment/procedure/surgeries that are not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that Macula RetinaVitreous Center has put in place reasonable safety measures to help reduce the spread of COVID-19, based on federal, state and local guidelines. I further understand that these measures cannot guarantee that I will not be exposed to COVID-19 while being treated at the Center.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or Imay 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 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 treatment/procedure/surgery may result in 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. Aftermy elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this **AND** future visits may put me at increased risk for becoming infected with COVID-19. By signingthis consent form, I accept that risk and give my permission to proceed with evaluation **AND** future treatment/procedure/surgeries listed below.

I have been given the choice to have my evaluations and/or treatments/procedures/surgeries at a later date. Iunderstand the potential risks of delaying and want to proceed.

I have read this consent, or someone has read it to me.

_____ Patient or Person authorized to sign for Patient

_____ Date