




## CONSENT FOR CARE AND TREATMENT:

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Dekalb Eye Consultants. Treatment provided by medical providers, nurses, and medical assistants at Dekalb Eye Consultants may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Dekalb Eye Consultants. I understand that all supplies, medical devices and other goods provided to Patient are provided by Dekalb Eye Consultants AS IS and Dekalb Eye Consultants disclaims any expressed or implied warranties.

Patient Rights: I have been provided information regarding Patient Rights and Responsibilities. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Dekalb Eye Consultants.

Communicable Disease Testing: I agree that if a Dekalb Eye Consultant employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Illinois law, Dekalb Eye Consultants may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Dekalb Eye Consultants may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Dekalb Eye Consultants can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended

as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____ TIME: _____