Lederman & Lederman, LLP
Covid – 19 Informed Consent

I understand I am giving this informed consent to Lederman and Lederman, LLP Pediatric Ophthalmology (the "Practice") to receive services at the Practice prior to any vaccine or known effective treatment to the CoronaVirus-COVID-19. I understand that the Practice has adopted recommended protocols for the prevention of COVID-19 at its facility. I have been advised I can request additional information prior to signing this consent, and at any time thereafter, as to the specific protocols in place regarding the Practice response to COVID-19.

By signing below, I acknowledge my understanding that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be highly contagious. I understand the Practice will be treating patients other than myself at its facility, as well as employing personnel who may be asymptomatic or qualified as "recovered" in accordance with CDC guidelines. I understand that it is impossible to determine who has it and who does not, at any given time, even as testing becomes readily available. I understand it is my responsibility to notify the Practice if I am medically "high risk" for any reason.

By signing below, I hereby agree to release the Practice, and its owners, members, officers, employees, contractors, agents, and representatives ("Practice Representatives"), and covenant not to commence or maintain any action or proceeding against any Practice Representatives, for or from any and all claims, causes of action, liabilities, damages, fees (including attorney's fees and costs of defense) and demands whatsoever, in law or equity ("Claims"), which I (and my heirs, executors, administrators and assigns) shall or may have, or from any person or entity other than myself, for, upon, or by reason of my contracting COVID- 19, including any claim resulting from my transmission of COVID-19 to any other person or thing. I hereby agree to indemnify and hold the Practice Representatives harmless from and against any and all Claims from or against any person or entity other than myself relating to my having or transmitting COVID-19.

By signing below, I acknowledge I have read this Informed Consent and I hereby agree to its terms and I assume the risk of potential Covid-19 exposure by receiving treatment at the Practice.

Patient Name: _____

Patient or Parent/Guardian Signature: _____

Relationship to Patient: _____

Dated: _____