MILAUSKAS
EYE INSTITUTE
The Desert's Leader in Eye Care

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 Milauskas Eye Institute. Treatment provided by medical providers, nurses, and medical assistants at Milauskas Eye Institute 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 Milauskas Eye Institute. I understand that all supplies, medical devices and other goods provided to Patient are provided by Milauskas Eye Institute AS IS and Milauskas Eye Institute 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 Milauskas Eye Institute.

Communicable Disease Testing: I agree that if a Milauskas Eye Institute employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Milauskas Eye Institute law, Milauskas Eye Institute 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 Milauskas Eye Institute may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Milauskas Eye Institute 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: _____