VARSHNEY OPTOMETRY
your eyes, our focus

2011 Plains Road E, Unit 3
Burlington, ON
L7R 0A6

T: (905)-681-VARS(8277)
F: (905)-681-3989
E: info@varshneyoptometry.com

CONSENT TO TELE-OPTOMETRY SERVICES

I, _____,
Name of Patient

OR

I, _____, on behalf of _____,
Name of Substitute Decision-Maker *Name of Patient*

confirm that I:

- Have read the Tele-Optometry Patient Information Sheet and understand and accept the risks and limitations associated with the receipt of Tele-Optometry Services via the Tele-Optometry Technology
- Have been advised of and understand the nature, material risks, consequences, side effects, expected benefits of and alternatives to the Tele-Optometry Services
- Will abide by the Patient Responsibilities set out in the Tele-Optometry Patient Information Sheet, as well as any other terms and conditions required of me by the Optometrist in respect of the Tele-Optometry Services
- Have had the opportunity to ask questions regarding the Tele-Optometry Services and have received answers to all of my questions
- Understand that I may withdraw my consent to the Tele-Optometry Services at any time
- Consent to receipt of the Tele-Optometry Services

CONSENT TO ELECTRONIC COMMUNICATIONS

With your consent, the Optometrist may communicate with you via text message, email or other forms of electronic communication ("***Electronic Communications***") for administrative purposes such as appointment scheduling, confirmation and cancellation, and to provide information and consent forms, as well as information about services, programs and other offerings.

☐ Yes, I consent to receive Electronic Communications

☐ No, I do not consent to receive Electronic Communications

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_____
Email Address

_____
Phone Number

_____
Signature of Patient(Enter Name to Sign)

_____
Relationship to Patient (if applicable)

_____
Date

For completion by Optometrist for obtaining verbal consent:

I have reviewed and discussed the contents of the Tele-Optometry Patient Information Sheet and this Tele-Optometry Consent Form with the patient/substitute decision-maker and:

- ☐ The patient/substitute decision-maker has provided their verbal consent to receive Tele-Optometry Services
- ☐ The patient/substitute decision-maker has provided their verbal consent to receive Electronic Communications.

_____ _____
Name/Signature of Optometrist *Date*

You can withdraw your consent to receive Electronic Communications at any time by contacting info@varshneyoptometry.