

Advanced Eyecare Solutions Form to Decline Treatment

The purpose of this form is to ensure that the parent/guardian named below understands the potential consequences of NOT commencing with the myopia treatment program recommended by Advanced Eyecare Solutions for their child/ward, identified below as the "Patient." You have the right and the obligation to make decisions regarding your child's health care. Advanced Eyecare Solutions can provide you with information and advice, but as a member of your child's health care team, you must participate in the decision making process. This form acknowledges your decision to decline the treatment recommended by Advanced Eyecare Solutions.

Dr. Sarbjit Virk has recommended myopia treatment for the patient named below. That recommended treatment would be:

- ☐ Atropine eye drops to slow or stop the progression of myopia (nearsightedness)
- ☐ Custom designed contact lenses to be worn overnight to slow or stop the progression of myopia (nearsightedness)
- ☐ Custom designed contact lenses to be worn during the day to slow or stop the progression of myopia (nearsightedness)

The possible benefits of proceeding with the recommended treatment include reducing the strength of future eyeglasses or contact lenses to correct blurry vision from myopia and decreasing the risks of certain sight threatening eye diseases.

The possible risks and complications of refusing the recommended treatment may include, but are not limited to, certain retinal diseases, glaucoma, cataracts and possible permanent vision loss. These potential risks and complications could result in additional medical procedures.

I have chosen to decline the above recommended treatment for my child. I certify that I have read, or had read to me, the contents of this form. I understand the possible advantages of proceeding with the recommended treatment and the possible risks and consequences of refusing the recommended treatment. I have decided to decline the treatment recommended by Advanced Eyecare Solutions. I hereby release Dr. Sarbjit Virk and his/her employees, partners, agents, or related corporations from any liability for any and all injuries and damages my child may sustain as a result of my refusing the recommended treatment. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Date: ____/____/____

Patient name (print): _____

Parent/Guardian name (print): _____

Parent/Guardian signature: _____

Witness name (print): _____

Witness signature: _____

Optometrist name (print): _____

Optometrist signature: _____

