CENTRAL PIEDMONT
COMMUNITY COLLEGE

# Central Piedmont Eye Clinic

## Patient Informed Consent

As a patient, I acknowledge that the Central Piedmont Eye Clinic functions primarily as a training facility for students enrolled in the Ophthalmic Medical Personnel Program. The facility provides patient centered eye care services including history taking, visual acuity, and ocular testing as indicated to members of the community as an integral part of the students' clinical skill development. I acknowledge that the Central Piedmont Eye Clinic recommends that I have an ophthalmologist or optometrist to supervise students during the clinic.

**In agreeing to be a patient at the Central Piedmont Eye Clinic, I further acknowledge and agree to the following conditions:**

- Student ophthalmic medical assistants are performing ocular exam services in a learning environment under the supervision of faculty and an ophthalmologist or optometrist.
- The Central Piedmont Eye Clinic requires a 24 hour cancellation notice to 704-330-2722 ext. 3444. Two canceled appointments or last minute cancellations may result in dismissal from the clinic.
- Consistent with the Central Piedmont Eye Clinic Privacy Policy, patient information/records will be kept confidential and patient privacy will be maintained.
- In the event of an accidental exposure incident in which a student, faculty member or another member of the clinic personnel is exposed to a patient's blood through a needle or instrument stick, the patient involved will be required to obtain a blood test for Hepatitis B, Hepatitis C, and HIV at the cost of the college. The results of the test will be made available to the student and the patient if necessary.

**I accept all of the above conditions and hereby give my consent to the Ophthalmic Medical Personnel faculty, students of Central Piedmont Community College and physician to render any eye health services deemed necessary for me or for my dependent(s).**

Signature: Date:

## Eye Clinic Privacy Policy

Your medical records are confidential. This information will only be utilized as outlined in the Notice of Privacy Practices. If you have any questions regarding this policy, please ask the student or physician providing your treatment. Please sign your name below indicating that you have read and accepted the Central Piedmont Community College Ophthalmic Medical Personnel Program Notice of Privacy Practices.

Signature: Date: