

Consent Form for Medical Treatment

Patient Name: _____ D.O.B. _____

Address: _____ Phone number: _____

Treatment with MacuMira Microcurrent Electrical Stimulation for Dry Age-Related Macular Degeneration (Dry AMD)

I, the undersigned, hereby consent to undergo treatment with MacuMira Microcurrent Electrical Stimulation for Dry Age-Related Macular Degeneration (Dry AMD) to be performed under the direction of

Dr. Dr. Angela Regier _____ at West 5 Optometry _____.

Purpose and Description of Treatment: MacuMira Microcurrent Electrical Stimulation involves the use of low-level microcurrent currents delivered through the closed eyelid into the retina. The purpose of this treatment is to potentially improve visual function of patients with Dry AMD.

Procedure: During the 32-minute non-invasive treatment session, a headset device will be used, electrodes will be placed in close proximity to the eye, and a low-level microcurrent will be applied to the closed eyelid covered with gel.

Authorization for Treatment and Sharing of Information: I consent that information about this procedure, including follow-up visits, may be shared with other healthcare providers for my care. I consent that the provider above may have other practitioners and clinical staff assist them, including trainers and trainees, and may permit them to perform all or part of my treatment. I also consent that these other healthcare providers may exercise the same discretion in my treatment or procedure as the provider named above.

Expected Benefits: Potential improvement in vision and/or contrast sensitivity.

Risks and Side Effects: While rare, possible risks and side effects include allergic reaction to gel

Contraindications: I understand MacuMira electrical stimulation treatment is contraindicated in patients who have a pacemaker or cochlear implant.

Confidentiality: All personal health information will be kept confidential and in accordance with applicable laws and regulations.

Voluntary Participation: I understand that participation in this treatment is voluntary, and I have had the opportunity to ask questions and have received satisfactory answers regarding the nature and purpose of the treatment, as well as its risks and benefits.

Consent: By signing below, I voluntarily consent to undergo treatment with MacuMira microcurrent electrical stimulation for Dry Age-Related Macular Degeneration (Dry AMD) and acknowledge that no guarantees have been made regarding the outcome of this treatment.

I acknowledge that I've had enough time to consider and understand the information before signing. I have the right to withdraw consent at any time without affecting my current or future medical care.

Patient's Signature: _____ Date: _____

Witness's Name & Signature (if applicable): _____