PersonalEYES VISION CARE

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www.PersonalEyesVisionCare.net

Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

Patient Name: _____

Patient Date of Birth: ___ / ___ / ___

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have been presented with a *Notice of Privacy Practices* from PersonalEYES Vision Care, L.L.C., and have been offered to keep such a document for my personal records. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I understand that I may revoke this consent in writing at any time.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Signature Printed Name

Source of Authority: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

*I do not wish to receive appointment reminders and notifications of received eyewear via automated text messages and voicemails. _____ Patient Initials

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(FOR OFFICE USE ONLY)

I tried to obtain written acknowledgement from the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because: ___An emergency prevented us from obtaining acknowledgement.
___A communication barrier prevented us from obtaining acknowledgement.
___The individual was unwilling to sign.
___Other:_____

Staff Member Signature_____ Date_____