

**ACKNOWLEDGMENT OF RECEIPT OF THE
NOTICE OF PRIVACY PRACTICES**

I understand that as part of my healthcare, Associates in Eyecare, P.C. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third party payer can verify that services billed were actually provided,
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professions, and
- A means by which payment for services can be made.

I acknowledge that Associates in Eyecare, P.C. has provided me with a copy of its NOTICE OF PRIVACY PRACTICES (“NOTICE”) that provides a more complete description of information uses and disclosures.

I understand that for convenience or necessity I would like my health information available to the following friends, family members, or physicians:

_____	_____
_____	_____

Patient Signature

Date