Patient Name: _____ Patient DOB: _____

I acknowledge receipt of Advanced Eyecare's Notice of Privacy Practices.

Signature of Patient/Legal Representative: _____ Today's Date: _____

****

Office Use:

To be completed if no signature is obtained. If it is not possible to obtain acknowledgment, describe the good faith efforts made to obtain acknowledgment, and the reason why it was not obtained.

Reason: _____

_____

Signature of Advanced Eyecare's Representative: _____

Printed Name: _____ Date: _____