ACKNOWLEDGEMENT

OF
NOTICE OF PRIVACY PRACTICES

The law requires that Visionary Eye Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- □ I have read, or have had explained to me, Visionary Eye Center's Notice of Privacy Practices prior to any services offered at Visionary Eye Center and agree to continue my care with Visionary Eye Center under said terms.
- □ I declined to read Visionary Eye Center's Notice of Privacy Practices, but wish to continue my care with Visionary Eye Center under the terms of Visionary Eye Center's Privacy Policies.
- □ I have read, or have had explained to me, Visionary Eye Center's Notice of Privacy Practices prior to any services offered at Visionary Eye Center and do not wish to continue my care with Visionary Eye Center under said terms.

_____
Patient Name, printed

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient Date