HIPAA PRIVACY ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________________ [Please **print** full legal name here] (the "Patient" or "Patient's legal representative") have been presented with the Notice of Privacy Policy (the "Policy") of Contact Lens and Vision ("the Provider"), and have been offered a copy of such policy to keep for my records.

__________ [Please **initial** here] I hereby acknowledge that I have been provided with a copy of the Policy.

__________ [Please **initial** here] I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

X____

Signature of Patient or Patient's legal representative **Date**

For Office Use Only

I, ______________________________________ [Please print full legal name here]. Acting as ____ [Please print relationship to or official position with provider] for Provider attempted to obtain the written acknowledgement of receipt of the Policy of Provider on _________________________ [Please insert date attempt was made], but acknowledgement could not be obtained because:

_________ [Please initial here] Patient or Patient's legal representative refused to sign.

_________ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgement.

_________ [Please initial here] Emergency circumstances prevented securing acknowledgement.

_________ [Please initial here] Other (Please specify)

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X____ ___________________

Signature of Provider Representative **Date**