ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Vision Care Associates LLP make every effort to inform you of your rights related to your personal health information.

By my signing below, I acknowledge that:

- [X] I have read or had explained to me prior to any services offered Vision Care Associates LLP's Notice of Privacy Practices and agree to continue my care with Vision Care Associates LLP under said terms.
- [ ] I was given the opportunity to read Vision Care Associates LLP's Notice of Privacy Practices and declined but wish to continue my care with Vision Care Associates LLP under the terms of Vision Care Associates LLP's privacy policies.
- [ ] I have read or had explained to me prior to any services offered Vision Care Associates LLP's Notice of Privacy Practices and do not wish to continue my care with Vision Care Associates LLP under said terms.
- [ ] The Notice of Privacy Practices could not be read due to the emergent nature of the care or other reason described.

_____

_____

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

_____ _____

Patient Date

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

_____ _____

Representative Relationship to Patient