Acknowledgement Of Privacy Practices

I, _____ acknowledge that I have received a copy of the Notice of Privacy Practices from Your Family Eye Doctors, Inc.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

_____	_____	_____
Name	Relationship	Date of Birth
_____	_____	_____
Name	Relationship	Date of Birth

I hereby consent to any necessary medical diagnosis and treatment for myself or the above named patient for whom I am legally responsible. I hereby authorize Your Family Eye Doctors, Inc. to release information required to process my health care claims and also that payment of insurance benefits be made payable to Your Family Eye Doctors, Inc. on my behalf for any services furnished. I hereby acknowledge and accept final responsibility for payment of services rendered.

The doctors and staff at Your Family Eye Doctors respect your time and we ask for the same courtesy. If you are unable to make your appointment, we ask that you notify our office at least 24 hours in advance. Failure to cancel an appointment that you do not attend will be considered a no show appointment.

Patient Signature:_____ Date:_____

Parent/Guardian: _____ Relationship:_____