ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR PHYSICAN'S EYE CENTER/SINGLAEYEINSTITUTE

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that XXX provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient