NOTICE OF PRIVACY PRACTICE-PATIENT ACKNOWLEDGEMENT
FAMILY VISION CENTER-DR. SUSAN ORVIS

Patient Name;_____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I do/do not (circle one) give permission for Family Vision to release billing information to:

Circle all that apply: spouse, parent, other:_____ Relationship of other: _____

(___) I am paying cash for my treatment and I am instructing the doctor to not release any information to my insurance company.
(check box if applicable)

SIGNATURE;_____ Date:_____

Office Use Only

( ) Patient took Notice ( ) Patient declined to take Notice

( ) Notice given to minor and instructed to give to parent/legal guardian Revised 4/2013