ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have reviewed Fort Mill Vision Center's Notice of Privacy Practices;

Please initial below if you would like a copy of the Privacy Practices:

____ No, I do not wish to receive a copy of Fort Mill Vision Center's Notice of Privacy Practices

____ Yes, I would like to receive a copy of Fort Mill Vision Center's Notice of Privacy Practices

Patient Name_____ Signature _____

Date _____

Due to HIPAA regulations – If you are over 18 years of age, please list any authorized person(s) with whom we can discuss your appointments, insurance and/or payments with (i.e. spouse, parent, etc.)

Name of Authorized Person(s):	**Relationship to Patient:**	**Type of Communication Authorized:**
_____	_____	☐ Exam Information ☐ Billing/Insurance
_____	_____	☐ Exam Information ☐ Billing/Insurance
_____	_____	☐ Exam Information ☐ Billing/Insurance