



ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that PREMIER VISION SERVICES, LLP make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

- I have read or had explained to me by a representative from PREMIER VISION SERVICES', LLP the *Notice of Privacy Practice*, and I agree to continue my care with PREMIER VISION SERVICES, LLP under said terms.
- I was given the opportunity to read the *Notice of Privacy Practices* by PREMIER VISION SERVICES, and declined. I wish to continue my care with PREMIER VISION SERVICES, LLP under the terms of the PREMIER VISION SERVICES privacy policy.
- I have read or had explained to me PREMIER VISION SERVICES', LLP *Notice of Privacy Practice* and do not wish to continue my care with PREMIER VISION SERVICES, LLP under said terms.
- The *Notice Of Privacy Practice* could not be read due to the emergent nature of the care or other reason described as:

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

Patient/Representative

Date

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

Representative

Relationship To Patient