



Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have the right to obtain a paper copy of A New Concept Optical & Eyecare’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time I may contact this facility at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to so as documented below:

Date: _____ **Initials:** _____ **Reason:** _____