ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

Please choose only **one** of the following options and sign below.

I acknowledge that:

- ☐ **I have read or had explained to me** TMS Eyecare's Notice of Privacy Practice and I agree to continue my care with TMS Eyecare under said terms.

- ☐ **I was given the opportunity to read** TMS Eyecare's Notice of Privacy Practice and I **chose not to read it** but wish to continue my care with TMS Eyecare under said terms.

- ☐ **I have read or had explained to me** TMS Eyecare's Notice of Privacy Practice and **DO NOT wish** to continue my care with TMS Eyecare under said terms.

- ☐ The TMS Eyecare Notice of Privacy Practice could not be read due to the emergent nature of visit or other reasons.

If you would like to allow us permission to share your protected health information with anyone, please list them here:

_____

_____

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

Print Name: _____

Signature: _____ Date: _____/_____/_____

If you are signing as a personal representative of the patient, please indicate your name and relationship to the patient.

Name/relationship (please print):_____

Signature: _____ Date: _____/_____/_____