EYE SPECIALTY GROUP
Your Vision Partner

REGISTRATION FORM

Patient Name (Last, First, Middle Initial)	Sex	Date of Birth / /	Marital Status	Race	Social Security Number

Patient Address	City	State	Zip Code	Patient Phone Number ( )

Patient Email Address

Patient Employer	Occupation & Department

Employer Address	City	State	Zip Code	Work Phone Number ( ) Ext.

Spouse/Guardian/Guarantor (Last, First, Middle Initial)	Date of Birth / /	Relationship to Patient ☐ Spouse ☐ Guardian ☐ Parent	Social Security Number

Spouse/Guardian/Guarantor Address	City	State	Zip Code	Spouse/Guardian/Guarantor Phone#

Spouse/Guardian/Guarantor Employer	Work Phone Number ( ) Ext.

Spouse/Guardian/Guarantor Employer Address	City	State	Zip Code

Primary Insurance Company	Address	City	State	Zip Code	Relationship to Insured ☐ Self ☐ Child ☐ Spouse ☐ Other
Primary Insured Name	**Group Number**	**Policy #, ID #, or Certificate #**	**Date of Birth**		INS. #
Secondary Insurance Company	**Address**	**City**	**State**	**Zip Code**	☐ Self ☐ Child ☐ Spouse ☐ Other
Secondary Insured Name	**Group Number**	**Policy #, ID #, or Certificate #**	**Date of Birth**		INS. #

Is this visit related to an accident or on the job injury? If yes complete back of form.

Primary Care Physician Name	Address	City	State	Zip Code	Phone Number

Emergency Contact?	Address	City	State	Zip Code	Phone Number

How did you learn of our office? (Please check one)

☐ Referring doctor (please specify)____________________

☐ Friend/relative ☐ Yellow Pages

☐ TV ☐ Other

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR SCANNING/PHOTOCOPYING

______________________________ ____/____/____
Patient or Legal Guardian Signature Date

IF ACCIDENT RELATED PLEASE COMPLETE

Date of accident____________________ Accident Details ____________________________________

____

____

Is this result of an motor vehicle accident? _______________________________________

Automobile insurance company name ____

Phone #_______________ Address ____

Policyholder Name______________________________________ Phone # ______________

Address ____

IF AN ON-THE-JOB INJURY, PLEASE COMPLETE

Date of accident____________________ Accident details ____________________________________

____

____

Was the accident reported to your employer?______________ Date reported ______________

Employer name ____

Address ____

Phone #____________________ Contact person _____________________________________

Workers compensation insurance company name ______________________________________

Claims mailing address ____

If legal matter, please give attorney's name, address and phone #.

Name____

Address ____

Phone # ____

EYE SPECIALTY GROUP
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PATIENT HISTORY

Date ____________________

Name ____ D.O.B. ____/____/______ Date of **Last Eye Exam** ____/____/____

Current Medications

List any **medications** you take (Rx and over-the-counter): ____

____

Eye Drops: ____

Allergies

List any **medication, latex, or food allergies:** ____

____

Eye History

Please check any **eye conditions** you have been diagnosed with or treated for (**Please list surgery dates if applicable**):

☐ Glaucoma ☐ Cataracts .... Surgery Date: Right ____________ Left ____________
☐ Iritis ☐ Retina/Macula Disease....Surgery Date: Right ____________ Left ____________
☐ Corneal Disease ☐ Injury .... Explanation: ____________________________
☐ Dry Eyes ☐ Other eye disorder ....Explanation: ____________________________

Medical / Surgical History

Please check any **medical conditions** you have been diagnosed with or treated for (**Please list surgery dates if applicable**):

☐ Heart Disease ☐ High Cholesterol ☐ Lupus ☐ Asthma
☐ High Blood Presure ☐ Lung Disease ☐ HIV ☐ Hepatitis Type______ How long?__________
☐ Heart Attack ☐ Stroke ☐ Pregnant/Nursing ☐ Cancer Type____________________
☐ Arthritis ☐ Thyroid Problems ☐ Blood Transfusion ☐ Diabetes Type______ How long?__________
☐ Kidney Disease ☐ TB Positive ☐ Other: ____________________________

Please list any **surgeries** you have had: ____

____

Family History

Please check if a family member (Mother, Father, Grandparent, Sibling) have been diagnosed with:

☐ Blindness ☐ Glaucoma ☐ Retinal Disease ☐ Cataract
☐ Heart Disease ☐ Diabetes ☐ Hypertension ☐ Stroke
☐ Cancer ☐ Thyroid Disease ☐ Arthritis ☐ Others Inheritable Disease: ____________

Social History

Please check any that apply to you:

Do you drink alcohol ?... ☐Yes ☐ No ... How much? ________ **Do you smoke** ?...☐Yes ☐ No... How much and how long? ________

Symptoms

Please check any problems you currently have:

Constitutional:
☐ Fatigue
☐ Fever
☐ Night Sweats
☐ Weight Gain
☐ Weight Loss
☐ None

Cardiovascular:
☐ Chest Pain
☐ Irregular Heart Beat
☐ None

Metabolic/Endocrine:
☐ Excessive Thirst
☐ Excessive Hunger
☐ Excessive Urination
☐ None

Skin:
☐ Hives
☐Rash
☐Warts
☐Growths
☐ None

HEENT:
☐ Hearing Loss
☐ Nasal Congestion
☐ Sinus Problems
☐ Sore Throat
☐ None

Gastrointestinal:
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Nausea
☐ None

Neurological:
☐ Dizziness
☐ Localized Weakness
☐ Headache
☐ Numbness
☐ Seizures
☐ None

Musculoskeletal:
☐ Joint Pain
☐ Joint Stiffness
☐ Joint Swelling
☐ Muscle Cramping
☐ None

Respiratory:
☐ Cough
☐ Difficulty Breathing
☐ Wheezing
☐ None

Urinary:
☐ Painful Urination
☐ Urgent Urination
☐ None

Psychiatric:
☐ Depression
☐ Insomnia
☐ Nervousness
☐ None

Hematologic:
☐ Bleeding Tendencies
☐ Anemia
☐ None

Immunologic:
☐ Environmental Allergies
☐ Seasonal Allergies
☐ None

EYE SPECIALTY GROUP
Your Vision Partner

Date: ______________________

Initial Each

___ **CONSENT FOR TREATMENT:** I voluntarily consent to the rendering of care by the physicians and supervised staff of the VRF-Eye Specialty Group, PLC (ESG).

___ **RELEASE OF INFORMATION:** I grant consent to ESG to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. My signature below indicates that I have been provided the ESG's Notice of Privacy Practices (NPP). It describes my rights and the duties of the ESG with respect to my protected health information, and provides more detailed information about how they may use and disclose my protected health information. I understand that I have the right to request a restriction as to how my protected health information may be used, but that ESG is not required to agree to the restriction. I understand I have the right to revoke this consent, in writing, at any time, except to the extent that ESG has already taken action in reliance on the consent. ESG reserves the right to change the NPP, and I understand that I may request and obtain a copy of the revised notice.

I hereby authorize ESG to disclose my health information to: ☐ **Family** ☐ **Establishment or individuals participating in my care.**

Do not disclose my protected health information to the following: ______________________

____

___ **ASSIGNMENT OF BENEFITS:** I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to ESG for any services furnished me. I authorize any holder of my medical information to release information needed to determine these benefits to CMS (Centers for Medicare and Medicaid Services), its agents, or any insurance carrier I may have. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

___ **FINANCIAL AGREEMENT:** I agree that I am responsible for payment for services provided by ESG. If uninsured, payment is required on the day of service. If insured, I understand that claims will be filed with my insurance company, and that I am responsible for any co-payments, co-insurance, and/or deductibles as designated by my health plan. I understand that the authorized co-payment of my health plan is to be paid on the date of service. I understand that it is my responsibility to inform the ESG of any changes in my personal information or insurance information, and that it is my responsibility to obtain appropriate referrals if required by my insurance company. If my account is sent to an attorney or collection agency for collection, I agree to pay all collection expenses and attorney's fees. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I agree to pay the returned check fee of $25 should my bank refuse to honor my check. I agree that ESG or any servicing agency retained by the facility to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Initial Each

AUTHORIZATION TO LEAVE MESSAGE

___ I hereby authorize ESG to leave a message regarding appointments or tests at my residence or cell phone.

AUTHORIZATION TO SEND APPOINTMENT REMINDERS OR OTHER ALERTS VIA TEXT MESSAGE OR AUTOMATED VOICE MESSAGING

___ I hereby authorize ESG to send appointment reminders to me via text message or automated voice message system. It is my responsibility to provide ESG with the most up to date contact information.

PHOTO CONSENT

___ I hereby authorize ESG to take my picture for my electronic medical record.

PRESCRIPTION CONSENT

___ I hereby authorize ESG to electronically access my prescription history through a prescription database compiling all prescription history.

____
Signature, Patient or Legal Representative

____
If Signed by Legal Representative, Print Name & Relationship

____
Print Patient's Name

____
Witness

Welcome to Eye Specialty Group! We know you have choices when it comes to your medical and surgical eye care provider. That is why our physicians and staff are dedicated to providing you with a superior medical experience. We are committed to doing our part and ask that you observe the following scheduling policies:

1. If you are unable to keep your appointment for any reason, please notify us by calling (901) 685-2200. Missed appointments cause disruptions in the schedule and increased costs to other patients of the practice. In order to defray those costs, patients who miss their appointments without providing prior notification will be charged a $25 fee.

2. You are welcome to arrive at the office as early as you wish but to avoid infringing on another patient's appointment we are unable to check you in to see the doctor more than 15 minutes prior to your scheduled appointment.

3. Patients arriving more than 30 minutes past their appointment time will be deemed to have missed their appointment and will be subject to the missed appointment fee provided above. Alternately, you may choose to stay and be seen immediately after the last scheduled appointment. If we have an earlier cancellation while you are waiting, we will be happy to provide you with that appointment time.

4. Every effort is made to follow our appointment schedule as closely as possible. While we cannot always predict the amount of time any patient will require, please be assured that every patient will receive the time and attention necessary to ensure excellent care.

At Eye Specialty Group, we appreciate both the opportunity and trust you have placed in us. We look forward to providing you with exceptional service!

_______________________________   __________________

Patient or Guardian   Date

NOTICE OF PRIVACY PRACTICES

This Notice is Effective as of September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and confidentiality and are committed to taking the steps necessary to safeguard any medical or other individually identifiable health information that is created by or provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of protected health information ("PHI"); (ii) provide notice of our legal duties and privacy practices with respect to protected health information; (iii) abide by the terms of our Notice of Privacy Practices currently in effect; and (iv) notify affected individuals following a breach of unsecured PHI. This Notice describes how we may use and disclose your PHI. It also outlines your rights and our legal obligations with respect to this PHI.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of our employees and staff as well as potential future organized health care arrangements. Organized health care arrangements ("OHCAs") include hospitals, physician organizations, health plans, and other entities that collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Officer. This notice applies to each of these individuals, entities, sites and locations. In addition, these individuals, entities, sites, and locations may share PHI with each other for the treatment, payment, and health care operation purposes described in this notice.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, phone number and email address.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse, or other medical providers.

In addition, we will gather certain medical information about you and will create a medical record of the care provided to you. This information may be stored in a paper chart and/or electronically. This medical record is the property of our ophthalmic practice, but the information in the medical record belongs to you.

Some information also may be provided to us by other individuals or organizations that are part of your "circle of care," such as your primary care provider, a referring physician, your other doctors, your health plan, and your close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

The law permits us to use and disclose personal and identifiable health information about you for the following purposes:

Treatment. We may use your PHI in order to provide your medical care. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes. We may disclose information to others who are involved in providing your care. For example, we may share your medical information with other health care providers who will perform services that we do not (such as your primary care physician or eye subspecialists); a pharmacist who needs your medical information to dispense a prescription to you; or a laboratory that performs a test we order for you.

Payment. We may use and disclose your PHI to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

Health Care Operations. We may use and disclose your PHI for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you. We may also share medical information

about you with the other health care providers, health care clearinghouses, and health plans that participate with us in OHCAs for any of the OHCAs' health care operations.

Required by Law. As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law.

Public Health. We may disclose your PHI to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability. We may also use and disclose your PHI in order to notify persons who may have been exposed to a disease or who are at risk of contracting or spreading a disease.

Abuse or Neglect. As required or authorized by law, we may disclose PHI to a public health authority or other government authority authorized by law to receive reports of child, elder, or dependent abuse or neglect or domestic violence.

Food and Drug Administration. We may disclose PHI to a person subject to the jurisdiction of the Food and Drug Administration for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls, repairs, or replacements; or to conduct post-marketing surveillance.

Serious Threat. Consistent with applicable law, we may disclose your PHI when necessary to prevent a serious threat to the health and safety of you or others.

Health Oversight Activities. We may disclose your PHI to health oversight agencies as authorized or required by law for health oversight activities such as audits, investigations, inspections, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions.

Judicial and Administrative Proceedings. We may disclose your PHI in the course of administrative or judicial proceedings (a) to the extent expressly authorized by order of a court or administrative tribunal or (b) in response to a subpoena, discovery request, or other lawful process that is not accompanied by a court or administrative order if reasonable efforts have been made to (i) notify you of the request and you have not objected or your objections have been resolved by a court or administrative tribunal or (ii) secure a qualified protective order.

Law Enforcement. We may disclose your PHI as required by law to assist law enforcement to identify or locate a suspect, fugitive, material witness, or missing person, or for purposes of complying with a court order, warrant, or grand jury subpoena.

Coroners and Funeral Directors. We may disclose a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors as necessary to carry out their duties.

Organ Donation. As authorized by law, we may disclose your PHI to organ procurement organizations, transplant centers, and eye or tissue banks.

Worker's Compensation. We may disclose your PHI as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.

Employers. We may disclose your PHI to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury.

Armed Forces. If you are a member of the Armed Forces, we may disclose your PHI for activities deemed necessary by military command authorities. We also may disclose health information about foreign military personnel to their appropriate foreign military authority.

Correctional Institutions. If you are an inmate, we may release your PHI to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health, or safety, or the health or safety of others.

National Security. We may disclose your PHI for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully, such as by providing billing services. We may disclose your PHI to these business associates so that they can perform the tasks that we hire them to do. We have written contracts with our business associates that require them and their subcontractors to protect the confidentiality and security of your PHI.

Notification and Communication with Family. We may disclose your PHI to notify persons responsible for your care about your location, general condition, or death. We may also disclose your PHI to someone who is involved with your care or helps pay for your care. Generally, we will obtain your oral agreement before using or disclosing health information in this way. However, under certain circumstances, such as

in an emergency situation, we may make these uses and disclosures without your agreement. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Disaster Relief. We may use and disclose PHI for disaster relief efforts.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Research. In compliance with governing law, we may use or disclose certain information about your condition and treatment for research purposes where your written authorization is not required and an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your PHI to prepare or analyze a research protocol and for other research purposes.

De-identified Information. We may create or distribute de-identified health information by removing all reference to individually identifiable information.

Marketing. We will obtain your prior written authorization before communicating with you (except face-to-face) about products or services related to your treatment or alternative treatments or therapies offered by a third party if we will receive any payment by such third party for this communication. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity if you revoke that authorization.

We do not need your authorization to send you reminders or information about appointments, treatment, or medication that you are currently prescribed, even if we receive compensation from a third party for doing so, as long as the compensation only covers the costs reasonably related to making the communication.

We may communicate with you without your prior authorization:
- about government or government-sponsored public benefit programs such as Medicare or Medicaid;
- about promotional gifts of nominal value;
- and to encourage you to maintain a healthy lifestyle, get routine tests, or participate in a disease management program.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment. If you are not home, we may leave this information in a telephone message or a message left with the person answering the phone.

Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information if you revoke that authorization.

Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities or to support organizations affiliated with this practice. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information, and health insurance status to indentify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed in this Notice and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

Psychotherapy Notes. If we have received your psychotherapy notes, we will not use or disclose them without your prior written authorization except for a few exceptions as provided by law.

Immunization Records. We may disclose PHI, limited to proof of immunization, to a school about an individual who is a student or prospective student if the school is required by law to have such proof and we obtain the agreement of the parent or guardian of the unemancipated minor or, if the student is an adult or emancipated minor, that individual.

OTHER USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

We are required to obtain written authorization from you for any uses and disclosures of PHI other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

To exercise any of your rights listed below, please contact our Privacy Officer in writing at the address listed below and include the details necessary for us to consider your request.

Restriction Requests. You have the right to ask for restrictions on certain uses and disclosures of PHI, including disclosure made to persons assisting with your care or payment for your care. We will consider your requests and notify you of the outcome, but are not required to accept such requests. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Restricted Disclosures to Health Plans. If you have paid for services "out of pocket" and in full, we will accommodate your request not disclose PHI related solely to those services to a health plan, unless we must disclose the information for treatment or as required by law.

Specific Communications. You have the right to request that you receive communications containing your PHI from us by specific means or at specific locations. For example, you may ask that we only contact you at home or by email. We will comply with all reasonable requests.

Inspect and Copy. With limited exceptions, you have the right to inspect and copy medical, billing, and other records used to make decisions about you. We will provide copies in the form and format you request if it is readily producible. If not, we will provide you with an alternative form and format you find acceptable. If we maintain records electronically and you request copies in an electronic form and format that is not readily producible, we will provide copies in a readable electronic form and format that you agree to. We will send a copy to any other person you designate in writing. We may charge you a reasonable fee for the cost of copying and mailing. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Amend or Supplement. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. When making a request for amendment, you must state the reason for making such request. Under certain circumstances, we may deny your request, such as when we do not have the information, the information was not created by us (unless the person or entity that created it is no longer available to make the amendment), you would not be permitted to inspect and copy the information, or the information is accurate and complete. If we deny your request you may submit a written statement of your disagreement with that decision. We may then prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

Accounting of Disclosures. You have the right to receive an accounting of disclosures of your PHI by our practice. We are not required to include in the list disclosures for your treatment, payment, our health care operations, and several other types of disclosures, such as those you authorize us to make, notifications and communications with family, and various government function and public health related disclosures. If you ask for this information from us more than once every twelve months, we may charge you a fee.

Breach Notification. In the case of a breach of unsecured PHI, you have the right to be notified, as provided by law. If you have given us a current email address, we may use it to communicate information related to the breach. In some circumstances, our Business Associate may provide the notification. We may also provide notification by other methods as appropriate.

Copy of Notice. You have the right to a copy of this notice in paper form. You may ask us for a copy at any time. You may also obtain a copy of this Notice on our website.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for all PHI we maintain and any we may receive in the future. In the event there is a material change to this Notice, the revised notice will be posted in our practice and on our website. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS

If you feel that your privacy protections have been violated by our office, you have the right to file a formal, written complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights at:

Office for Civil Rights:
U.S. Department of Health & Human Services
61 Forsyth Street, SW. - Suite 3B70, Atlanta, GA 30323
(404) 562-7886; (404) 331-2867 (TDD) • (404) 562-7881 FAX
or by email at OCRMail@hhs.gov.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights at Melinda Williams, 901.685.2200, privacyofficer@esg.md or Privacy Officer, Eye Specialty Group, 825 Ridge Lake Blvd., Memphis, TN 38120.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF THE EYE SPECIALTY GROUP

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices of the Eye Specialty Group.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative Authority