

**ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES**

The law requires that {Prestonwood Eyecare, David C. Moiger, O.D.} make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read or had explained to me {Prestonwood Eyecare, David C. Moiger, O.D.}'s Notice of Privacy Practice and agree to continue my care with {Prestonwood Eyecare, David C. Moiger, O.D.} under said terms.
- I was given to opportunity to read {Prestonwood Eyecare, David C. Moiger, O.D.}'s Notice of Privacy Practices and declined but wish to continue my care with {Prestonwood Eyecare, David C. Moiger, O.D.} under the terms of {Prestonwood Eyecare, David C. Moiger, O.D.}'s privacy policies.
- I have read or had explained to me {Prestonwood Eyecare, David C. Moiger, O.D.}'s Notice of Privacy Practice and do not wish to continue my care with {Prestonwood Eyecare, David C. Moiger, O.D.} under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

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

Patient

Date

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

Representative

Relationship to Patient