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5328 Main Street
Spring Hill, TN 37174

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Spring Hill Eyecare, PLLC has established a ***Privacy Policy*** and guidelines for ***Privacy Practices*** within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purpose of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

☐ I have read, understand, and acknowledge the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC.

☐ I have elected not to read the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC, but have been provided with a copy today.

Patient name _____

Signature (or patient's representative)_____Date_____

I understand that the Practice may wish to contact me for purposes related to my treatment such as to remind me of appointments, leave messages, or to discuss financial/billing business, or to indicate other necessary contacts.

Please Initial

_____ Yes, I authorize the Practice to contact me at the contacts (phone #s/email) I have provided. I understand and authorize the practice to leave me a voicemail message if I am unavailable.

_____ No. I do not agree to these contacts. Do not leave a message.

The following people may have access to my personal health information:

Name:_____Relationship:_____

Name:_____Relationship:_____