FAMILY eye care

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Family Eye Care's Notice of Privacy Practices

Patient Name: _____ Patient DOB: _____/_____/_____

Any physician, staff, employee or representative of Family Eye Care has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number(s)
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Family Eye Care calls and sends recall notices for appointments via mail by post card, or on occasion we may send an email or text message if we are unable to reach you by phone.

Please check if this is agreeable with you.

_____ Text
_____ Email
_____ Post Cards

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to Family Eye Care or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

Patient or Guardian Signature: _____ Date: _____/_____/_____

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Acknowledgement of Receipt of Notice of Privacy Practices (continued)

We use SOLUTION REACH network to communicate electronially with our patients via email and text. This network can notify you of your future appointments and alert you electronically when your glasses and/or contacts order is ready for pick-up. Shall you opt out of this service, you will NOT receive any further notification from our office.

Can we communicate with you via email? YES / NO

Can we communicate with you via text? YES / NO

LATE POLICY

If a patient is going to be late, we ask you call to let us know you are on your way. However, if you are going to be more than 15 minutes late, your appointment will be rescheduled.

NO SHOW POLICY

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. Patients who "NO SHOW" three times with no previous notification will not be allowed to schedule appointments with Family Eye Care.

Informed Consent/ Agreement:

I have been informed and understand Family Eye Care's late and no show policy.
YES / NO

Patient or Guardian Signature: _____ Date: _____/_____/_____