ATLANTIC FAMILY EYE CARE

DR. WILLIAM P. FREITAS ♦ DR. BRIAN P. KILEY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I received a copy of Atlantic Family Eye Care's Notice of Privacy Practices.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party providers.
- Conduct normal healthcare operations such as quality of assessments and physician certifications.

I understand that Atlantic Family Eye Care Inc. has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

DATE: _____ INITIALS: _____

REASON: _____

2345 MENDON ROAD ♦ WOONSOCKET, RI 02895 ♦
PHONE: (401) 765-5430 ♦ FAX: (401) 765-8175