ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, Arianna Bacon, understand that as part of my healthcare, Glens Falls Eye Associates, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations of Glens Falls Eye Associates, P.C. such as assessing quality of care and reviewing the competence of healthcare professionals

I understand that as part of the Glens Falls Eye Associates, P.C. treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a much more complete description of how Glens Falls Eye Associates, P.C. may use disclose my protected healthcare information. I further understand that Glens Falls Eye Associates, P.C. reserves the right to change its ***Notice of privacy Practices .*** Should Glens Falls Eye Associates, P.C. change its ***Notice of Privacy Practices***, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Glens Falls Eye Associates, P.C. may do the following unless I specifically give direction prohibiting such activity:

Send visit reminders and test results to the address I have provided.

Send routine correspondence, such as billing statements, to the address I have provided.

Leave messages on an answering machine or voice mail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

Patient Signature or Signature of Personal Representative

Date: November 29, 2017

==========

FOR OFFICE USE ONLY
☐ Receipt received to patient
☐ Patient refused to sign for receipt