Family Vision Practice
Dr. John Krebsbach
518 SE Oak, Suite 2020
Hillsboro, OR 97123
503-648-2020 Fax 503-648-0868

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name ________________________________ Patient Phone____________________
Patient Address ____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the **Notice of Privacy Practice.** Additionally, I acknowledge that payment of professional services and/or materials is my obligation, regardless of insurance or other third party involvement:

____ __________________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient:

____ ___________________________________
Relationship to Patient Print Name

8-18