Eyes4Kids

ACKNOWLEDGEMENT OF READ AND RECEIPT OF THE FOLLOWING DOCUMENTS:

1. **SERVICES NOT COVERED BY INSURANCE**
2. **NOTICE OF PRIVACY PRACTICES**
3. **DISCRIMINATION AGAINST THE LAW**

I, (name of Patient) _____, acknowledge and agree that I have read and received a copy of Pediatric Ophthalmology Consultants **Services Not Covered by Insurance, Notice of Privacy Practices, Discrimination Against The Law.**

Patient Signature	Date
Signature of Patient Legal Representative	Date
Print Name of Legal Representative	Relationship to Patient

FOR CLINICAL USE ONLY:

Pediatric Ophthalmology Consultants, made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of **Services Not Covered by Insurance, Notice of Privacy Practices, Discrimination against the Law.**