mt. pleasant EYE CARE CENTER, P.A.
BRIAN K. NICHOLS, O.D.
903-572-1991
www.mpeyecare.com

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES HIPPA

The law requires that Mt. Pleasant Eye Care Center, P.A., makes every effort to inform you of your rights related to your Personal Health Information.

The HIPPA Privacy Rule gives individuals the right to request confidential communications concerning their Protected Health Information (PHI) or that it is permissible to communicate PHI to alternate individuals.

Check your preferred contact method and provide the requested information:

Cell Phone #_____ YES ☐ NO ☐

May we leave a Voice Message? YES ☐ NO ☐ May we send a Text Message? YES ☐ NO ☐

Home Phone #_____ YES ☐ NO ☐

May we leave a Voice Message? YES ☐ NO ☐

I authorize Mt. Pleasant Eye Care Center P.A., to discuss my medical history or billing information with the following:

Spouse Name _____PH#_____

Parent Name _____PH#_____

Other Name _____PH#_____

By signing below, I acknowledge:

I have either read, declined to read, or had explained to me, Mt. Pleasant Eye Care Center, P.A.'s Notice of Privacy Practices.

In any of the aforementioned cases, I agree to continue my care with Mt. Pleasant Eye Care Center, P.A. under the terms and specifications set forth in Mt. Pleasant Eye Care Center P.A. Notice of Privacy Practices.
I have read and understand this policy. I am signing voluntarily.

Patient _____ Date_____

Parent Signature_____ Other_____
If patient is a minor Relationship to patient

By signing below, I acknowledge:

I **DECLINE** to accept the terms and specifications set forth in Mt. Pleasant Eye Care Center, P.A.'s Notice of Privacy Practices and fully understand that this necessarily, by default, results in the unfortunate inability of Mt. Pleasant Eye Care Center P.A. to satisfactorily serve my health care needs.

I have read and understand this policy. I am signing voluntarily.

Patient _____ Date_____

Parent Signature_____ Other_____
If patient is a minor Relationship to patient