To save time, please fill out this form and bring it to your appointment.

ACKNOWLEDGEMNT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES FOR

LAGUNA EYE CARE OPTOMETRY

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the Notice of Privacy Policies on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation)

Agent: _____

Title: _____