Consent to Treat & Receipt of Privacy Practices
Please complete & sign with **legal** name

Patient Name: _____ DOB: _____

Consent for Treatment:

I hereby consent to examination(s) treatment(s) and diagnostic evaluation(s). I understand I have the right to ask questions about my treatment and/or procedures, and I agree to notify my provider of my concerns.

I have read, understand, and agree to the information stated above:

Patient/Guardian Signature:_____ Date:_____

Notice of Privacy Practices Acknowledgement:

I have been provided a copy of Optix Eye Care **Notice of Privacy Practice**, detailing how my information may be used and disclosed under Federal and State Law.

Patient or Legal Guardian
Signature: _____ Date: _____

I give permission to Kim Walters, OD and Optix Eyecare associates to speak to the following designated persons regarding my personal health information which includes but is not limited to diagnosis, care, prescriptions and billing.

Name	Relation	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____