Please complete & sign with **legal** name

Printed Patient Name: ______________________________ Date of Birth: __________________

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Kim Walters, OD, PA (dba Optix Eye Care). The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Kim Walters, OD, PA (dba Optix Eye Care) with respect to my protected health information.

Patient/GuardianSignature:____________________________________ Date:_______________

Consent to Treat

Please complete & sign with **legal** name

I hereby consent to examination(s), treatment(s), and diagnostic evaluation(s) ordered and/or performed by Dr. Kim Crouch. 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/GuardianSignature:____________________________________ Date:_______________

Kim Walters, OD, PA

49 N. Buncombe Shchool Rd., Weaverville, NC 28787

Ph. (828) 645-0061 www.optix-eye.com