



Clafin Eye Care

For A Lifetime of Vision Health

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP):

My signature below acknowledges that I have received or have been offered a copy of the Clafin Eye Care Notice of Privacy Practices, and I am aware that I have access to this document on the Clafin Eye Care website at [http://www.claflineyecare.com/wp-content/uploads/2020/06/150-ClafinEyeCare\\_PrivacyNotice.pdf](http://www.claflineyecare.com/wp-content/uploads/2020/06/150-ClafinEyeCare_PrivacyNotice.pdf)

**OR**

#### **INTERNAL USE ONLY**

The Patient is unable to sign because Patient (either): \_\_\_ Is Critical or Unconscious\* **OR** \_\_\_ Refuses to Sign.

*\*In an emergency treatment situation, obtain the NPP acknowledgement as soon as it is reasonably practicable to do so after the emergency situation has ended.*

\_\_\_ CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (NPP): I hereby certify that as an associate or agent of Clafin Eye Care, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of receipt of the NPP in accordance with organization policy.

### SIGNATURE

Signature of Patient or Authorized Representative: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

*If signed by Authorized Representative*

Relationship to Patient/Authority to Sign: \_\_\_\_\_

Authorized Representative's Phone Number: \_\_\_\_\_

Authorized Representative's Address: \_\_\_\_\_

Reason Patient Unable to Sign: \_\_\_\_\_

Verbal Consent from Capable Patient if Unable to Sign:  Yes