Acknowledgment of Notice of Privacy Practices

Craig. A. Cassey, O.D., P.C.
4590 Edgmont Avenue, Brookhaven PA 19015
610-872-6077

The law requires that Craig. A. Cassey, O.D., P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

___ I have read or had explained to me prior to any services offered Craig. A. Cassey, O.D., P.C.'s Notice of Privacy Practice and agree to continue my care with Craig. A. Cassey, O.D., P.C. under said terms.

___ I was given an opportunity to read Craig. A. Cassey, O.D., P.C.'s Notice of Privacy Practices and declined, but wish to continue my care with Craig. A. Cassey, O.D., P.C. under the terms of Craig. A. Cassey, O.D., P.C.' privacy policies.

___ I have read or had explained to me prior to any services offered Craig. A. Cassey, O.D., P.C.'s Notice of Privacy Practice and do not wish to continue my care with Craig. A. Cassey, O.D., P.C. under said terms.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as:

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____
Patient

_____
Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____
Representative

_____
Relationship to Patient