Dr David A Kingrey and Dr Jeffrey A Boomer
Vision Surgery Consultants / Associated Eye Surgical Center

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Phone: (316) 263-6273 Fax: (316) 263-5568

218 S Kansas Ave, Newton KS 67114
Phone: (316) 283-1400 Fax: (316) 284-0015

PATIENT LEGAL NAME: ____

BIRTH DATE (MM/DD/YYYY):____________ /_______ / ________

IF YOU ARE NOT AVAILABLE - WHO MAY WE COMMUNICATE WITH?

Name:	Relationship:	Phone:
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________

Communicate with self **ONLY** ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from Associated Eye Surgical Center.

X______________________________________ ______________________________
Signature Date

If signing this as a personal representative of the patient, describe the relationship to the patient.

______________________________________ ______________________________
Signature Relationship to patient

____
Date

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For office use only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify) ____

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