Matrix Vision

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Matrix Vision's Notice of Privacy Practices.

Patient Name _____

Signature_____ Date _____

I acknowledge that I have been given the following options related to communicating with Matrix Vision, its doctors and staff members:

I agree to allow Matrix Vision doctors and staff member (who identifies the message as originating from Matrix Vision, individual optometrist and/or a staff member of Matrix Vision) to leave messages on my answering machine, answering service or with an individual at my home or workplace. I understand that clinical information will not be part of this message.

Please circle one of the following:

Yes, I agree No, I do not agree

I agree to allow Matrix Vision to send me marketing materials/ clinical information concerning services and/or products available at Matrix Vision. Such information will be mailed, emailed and/or otherwise delivered in an envelope, post-card, container or electronic communication& method that may contain my name and that of Matrix Vision and/or an individual optometrist providing care at Matrix Vision.

Please circle one of the following:

Yes, I agree No, 1 do not agree