Outside Contact Lens Order Form

Jenkins Vision Care

850 Prince Ave. Ste. B
Athens, GA 30606
PH: 706-353-2520
FAX: 706-353-2584

Name:_____
(Mr. / Mrs./ Miss / Dr) Last First

Address: _____E-Mail_____
Street City State Zip Code

Birth Date: ___ / ___ / ___ Age: _____ Home Phone: _____
(Area Code) + 7 digits

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ [Please print your full legal name here] (the "Patient" or "Patients legal representative", have been presented with the Notice of Privacy Policy (the "Policy") of *N.E. Ga. Vision Care, LLC. (dba Jenkins Vision Care)* and have been offered a copy of such policy to keep.

[Please initial **one** of the following]

___ I hereby acknowledge that I have been provided with a copy of the Policy.

___ I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, provider may still provide treatment to me.

Signature: _____ Date: ___ / ___ / ___
Must be at least 18 to sign, or parent or guardian MM DD YY

IMPORTANT ……**PLEASE READ CAREFULLY**

I understand that if the boxes of contacts are open, marked upon, or otherwise damaged then Jenkins Vision Care will not able to take them back. If the prescription is not satisfactory, then it is my responsibility to contact the prescribing doctor's office to seek a change in prescription.

Signature of Patient: _____ Date: ___ / ___ / ___
Must be at least 18 to sign, or parent or guardian MM DD YY