

**Acknowledgement of Receipt of
Notice of Privacy Practices**

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IMPORTANT ANNOUNCEMENT FROM YOUR DOCTOR

Batesville Eye Care Center is proud to provide our patients with the most highly advanced technology available in retinal screening today! Our ability to view your internal retinal health is now dramatically improved with the Optomap.

Dr. Davis is concerned about retinal problems such as macular degeneration, glaucoma, retinal holes or detachments and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, systemic diseases such as diabetes and high blood pressure can be detected during a retinal exam.

EARLY DETECTION IS CRUCIAL!!

Optomap Provides:

- An annual eye wellness scan
- An in depth view of the retinal layers (where disease can start).
- The ability to show you your images today during your exam.
- A permanent record for your medical file, which gives your doctor comparisons for tracking and diagnosing potential eye disease.

Optomap:

- Is fast, easy, and comfortable.
- **Will NOT require dilating drops (which result in blurred vision and sensitivity to light)** in most cases.

___ I elect to have an Optomap of my retina.

Patient Signature _____ Date _____

If you decline the Optomap exam, you are limiting our ability to accurately determine the health of your eyes and must sign below.

I decline the Optomap exam _____ Date _____

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operation involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Batesville Eye Care Center.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Relationship to Patient

Print Name

Source of Authority: