ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO TREAT

I give my consent to John E. Ellis, O.D. to perform optical and medical services determined to be necessary or advisable for the benefit of my health care. I acknowledge that I have received the Notice of Privacy Practices for John E. Ellis, O.D. John E. Ellis, O.D. is authorized to use and disclose my protected health information for treatment, payment and health care operations consistent with his Notice of Privacy Practices.

Print - PATIENT NAME	PATIENT SIGNATURE	DATE

INSURANCE SIGNATURE ON FILE

I authorize Dr. Ellis to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. John E. Ellis on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the appropriate insurance agent any information needed to determine benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes Dr. Ellis to act as my agent, as above.

Printed Name	Lifetime Patient Signature	Date