



Insight Vision Center
 3003 Cleveland Ave
 Marinette, WI 54143
 P:(715) 732-2101
 F:(715) 732-2355

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Andrew Congdon, O.D. & Kevin Congdon, O.D. Notice of Privacy Practices.

Patient name (please print): _____

I ACCEPT

Signature: _____

Date: _____

---OR---

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt/acknowledge of Notice of Privacy Practices with respect to the patient.

Name [please print]: _____ Relationship to Patient: _____

Parent Legal Guardian Signature: _____ Date: _____

I ACCEPT



Insight Vision Center
 3003 Cleveland Ave
 Marinette, WI 54143
 P:(715) 732-2101
 F:(715) 732-2355

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Andrew Congdon, O.D. & Kevin Congdon, O.D. Notice of Privacy Practices.

Patient name (please print): _____

I ACCEPT

Signature: _____

Date: _____

---OR---

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt/acknowledge of Notice of Privacy Practices with respect to the patient.

Name [please print]: _____ Relationship to Patient: _____

Parent Legal Guardian Signature: _____ Date: _____

I ACCEPT