11914 S. Route 59 #106
Plainfield, IL 60585-5110
815-676-4474
815-267-6521
staff@4sighticare.com
www.4sighticare.com

Welcome to 4Sight iCare; this form optimizes your visit to help you SEE YOUR BEST. Please give your eye care some 4-thought by telling us more about you...

Patient's First Name: _____ Preferred/NickName: _____ Last Name: _____ Date of Birth: _____

How did you first hear about us?

_____

Please select ALL that you currently use to SEE YOUR BEST.

☐ Digital Device Lenses ☐ Prescribed Eye Vitamins ☐ Prescription Eyewear ☐ Contact Lenses
☐ Vision Shaping Retainers ☐ Sunglasses ☐ Vision Training ☐ Medical Eye Care ☐ Eyelid Hygiene Regimen
☐ In-office Dry Eye Treatment ☐ Myopia Management ☐ Nothing besides an annual eye exam.

Would you like to know about treatments that improve the appearance of your eyes?

○ Yes ○ No

Last 4 digits of SSN# _____

Assigned Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married
○ Domestic Partner
○ Separated ○ Divorced
○ Widowed

Pronouns:
○ he/him ○ she/her
○ they/them

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email (for online portal login): _____

Preferred contact number:
○ Mobile Phone (with text reminders) ○ Home Phone ○ Work Phone

Primary Care Physician (PCP): _____ PCP Office Phone: _____

PCP Office Fax: _____ Preferred Pharmacy (name and location): _____

Dominant hand:
○ Right ○ Left

Occupation: _____

Hobbies: _____ Sports you play: _____

Approximate height in feet & inches: _____

Annual WELLNESS exams can be billed to VISION PLANS, MEDICAL visits are billed to MEDICAL INSURANCE and may require additional tests ordered by your doctor, and specialty eye care services are paid directly to the provider office. Which type of visit are you coming in for this time?

- ○ Annual Comprehensive WELLNESS Eye Exam
- ○ Annual Comprehensive MEDICAL Eye Exam with DILATION
- ○ Follow-Up or Emergency MEDICAL Eye Care (MEC, DEA)
- ○ Specialty Eye Care (MVP, VTE, MMP, VST)

We will prepare an eyewear quote at your comprehensive exam. Our state-of-the-art technology demonstrates your old prescription strength vs. your new one just by bringing in any current glasses. When the doctor performs a contact lens fitting & evaluation we can also provide a quote for contact lenses. Would you like contact lens services at this visit?

- ○ Yes, please provide an eyewear quote and a contact lens quote (requires a Contact Lens Fitting and Evaluation)
- ○ No, please provide only an eyewear quote and I'll skip the next 9 questions about contacts (I understand adding contact lens services later may cost more)

If you've worn contacts before, have you routinely worn contact lenses within the last 4 years?

- ○ Yes
- ○ No

If yes, please provide the brand name here if known:

_____

If you wear contacts, how often do your replace your lenses (discard them and put in a fresh pair)?

- ○ Daily
- ○ Weekly
- ○ Every 2 Weeks
- ○ Monthly
- ○ About every 6 weeks
- ○ Every 2 Months or so
- ○ Quarterly
- ○ Annually
- ○ Every few years or more

On average, how many times per week do you plan to wear contacts, if at all?

- ○ < 3
- ○ 3 to 4
- ○ 5
- ○ 6 to 7

For contact lens wearers, rank the importance of these contact lens properties: A) Comfort on eyes, B) Prevent CL complications, C) Sharp Vision, and D) Affordability

Most Important	2nd Most Important	3rd Most Important	Least Important
_____	_____	_____	_____

If any, what is your primary motivation to wear contacts?

- ○ Athletics
- ○ Enhanced eye color
- ○ Vision without glasses
- ○ Other

If Other, please specify:

_____

If this is your first fitting of contact lenses, we require a class on proper use of these medical devices. The doctor's yearly check of a diagnostic lens on the eye enables us to provide take home trials and a final prescription. This course can last up to 1 hour; it's best done at 4pm during the week or 1pm on Saturdays. Which day would you like to schedule your contact lens class?

○ 4pm on a weekday ○ 11 am on Saturday ○ No Class

All contact lens wearers need an up-to-date pair of prescription glasses for times you can't wear contacts. Prescription-quality lenses in non-powered sunglasses and digital device lenses are worn over contacts to protect your eyes from 100% UVA & UVB rays (UV400) as well as harmful blue light from the sun and digital devices. If fit in contacts, you'll receive 25% off these non-powered, pre-fabricated eyewear at our optical.

How many years old is your best pair of glasses? _____

Do you own a pair of sunglasses that protect your eyes and surrounding skin from 100% UVA & UVB? ○ Yes ○ No

Do you own a pair of blue-light-filtering glasses? ○ Yes ○ No

At 4Sight iCare our mission is to help you SEE YOUR BEST. Prevention is the best medicine and for this doctor-owned office that includes an annual iHealth Wellness Exam.

○ I'm happy to receive the appropriate iHealth Wellness Exam. Skip to page 5.

○ I shall review the following letter from the doctor and section so I know what to expect.

iHealth Wellness Exam

The iHealth Wellness Exam maintains a life of Healthy, Clear, Comfortable, Balanced Vision

The iHealth Wellness Exam is designed to help you SEE YOUR BEST	Medical **CPT** Code (AMA)	**Value of the service when ordered by your doctor**	**Nominal fee at your annual eye exam**
Spot Camera non-verbal eye test **(6 months+)**	99172	$58	**$0**
Retinal Photography **(4 years+)**	92250	$98	**$39**
Retinal OCT Scan **(4 years+)**	92134	$82	**$19**
Corneal Topography Check **(4 years+)**	92025	$44	**$0**
King-Devick Eye Movements **(6 years+)**	92499	$58	**$0**
Map of your Visual Field **(14 years+)**	92083	$84	**$20**
Contrast Sensitivity **(14 years+)**	99172	$58	**$0**
Inspect eyelid, oil-layer tear glands **(18 years+)**	92499	$58	**$0**

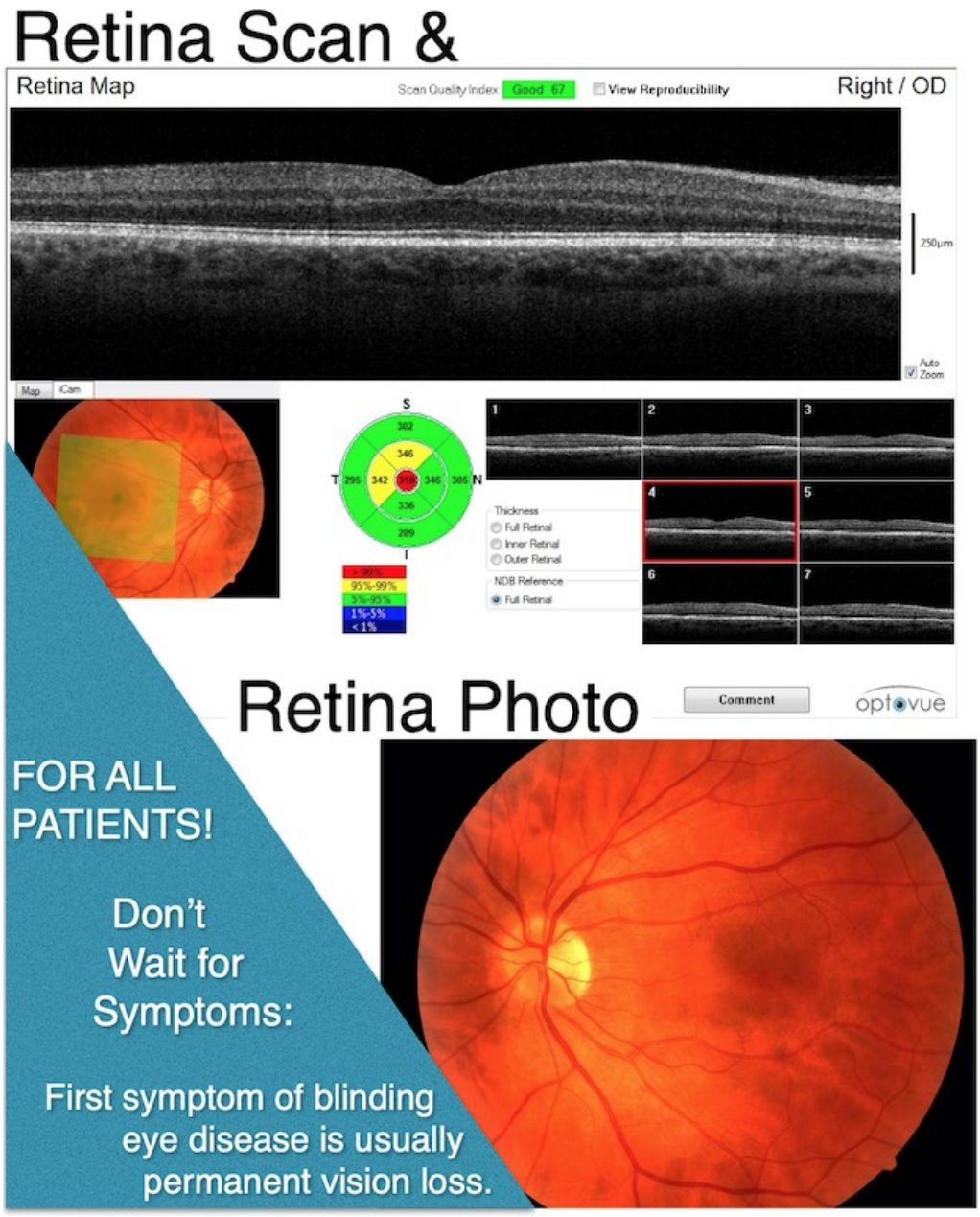
Dear patient,

The single most important reason for an annual eye exam is to ensure your eyes are Healthy; it's first on our list for a reason! Allowing your doctor to use those two windows into your health to identify early signs of underlying conditions is the best way to perform an annual eye exam. The view is so greatly enhanced by the iHealth Wellness Exam that I've requested all patients who are able receive the age-appropriate testing.

I started 4Sight iCare in 2015 so I could practice Optometry the way I would want for my family with the latest technology and the best outcomes. A nominal fee for each service allows us to continuously live up to our mission to help you SEE YOUR BEST. Our technicians shall perform the service(s) on everyone that meets the criteria explained in detail within the Patient Responsibility & HIPAA Privacy Consent. Should you need to request a one-time, financial hardship exception, please do so **at checkout** so that your care is still complete in the eyes of your eye doctor.

Sincerely,

Dr. Mark W. Burke



Check all that apply to immediate family member's history:

[Blank = None]	Father	Mother	Brother	Sister	Son	Daughter
Cancer						
Type 1 Diabetes						
Type 2 Diabetes						
Unspecified Diabetes						
Hyperthyroidism (high)						
Hypothyroidism (low)						
High Blood Pressure						
Cataract						
Macular Degeneration						
Glaucoma						

Any other relative suffer from an eye disease?

○ Yes ○ No

If yes, please write the condition and relative's relation:

_____

Personal Ocular History:

☐ Never had eye injury, surgery or disease
☐ Glaucoma
☐ Pre-glaucoma
☐ Age-related Macular Degeneration
☐ Cataract
☐ Eye Muscle Surgery
☐ Refractive Surgery (LASIK)
☐ Patching
☐ Inflammatory Eye Disorder
☐ Strabismus (eye turn)
☐ Ambloypia (lazy eye)
☐ Retinal Detachment
☐ Retinal Degeneration
☐ Retinal Hole
☐ Retina Surgery (including laser)
☐ Eye Injury or Other Ocular Condition (specify below)
☐ Keratoconus
☐ Dry Eye Disease
☐ Nystagmus
☐ Cataract Extraction
☐ Other (specified below)

If eye injury or other, please specify:

_____

Drug, alcohol & tobacco use:

Do you consume alcohol?
○ No ○ Socially
○ 1-2 drinks per day
○ 2-5 drinks per day
○ >5 drinks per day

Do you have a history of smoking cigarettes?
○ No ○ Yes, I currently smoke
○ Yes, but I quit less than 20 years ago
○ Yes, but I quit more than 20 years ago

If you currently smoke, how many cigarettes per day

Do you use recreational drugs?
○ No ○ Yes

If you use recreational drugs, please specify:

Please select any and all services beyond eyeglasses that you'd like to learn more about:

☐ MVP (Maximum Vision Protection/Performance) improve ocular nutrition

☐ VTE (Vision Training Evaluation) improve visual skills used in reading, sports, and life

☐ TCT (Tear Care Treatment) improve tears & eye comfort

☐ MMP (Myopia Management Program) protect my child from future problems

☐ VST (Vision Shaping Treatment) see without daytime lenses

☐ Co-managed Refractive Surgery

Please indicate when you choose to wear vision correction (eyeglasses or contact lenses)?

☐ All the time

☐ Reading up close

☐ Never

☐ Looking far away

☐ Working at a computer

While wearing your preferred vision correction, please rank your vision at each distance on a scale from 1 to 10 where 10 is your best vision.

Your Current Vision at...	1	2	3	4	5	6	7	8	9	10 (BEST)
..far away										
...reading up close										
...arm's length										

How often have you experienced each of these symptoms over the past 3 months:

How often do you experience:	Never	Rarely	Sometimes	Frequently	Constnantly
Eye discomfort or itch?					
Burning/Dry sensation?					
Gritty/Sandy sensation?					
Eye redness?					
Watery eyes?					
Fluctuating vision?					

Check all symptoms that you're experiencing now:

- ☐ Eye Pain
- ☐ Burning
- ☐ Eyestrain
- ☐ Discharge
- ☐ Double Vision
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Bothersome Glare
- ☐ Light Sensitivity
- ☐ Total Vision Loss
- ☐ Other
- ☐ None of these

If other, please specify:

_____

Indications for dilation include but are not limited to the following: pertinent family/personal history, recent injury, or abnormal tests results. Not having a dilated eye exam when indicated and/or failing to attend a prescribed problem-focused medical office visit may be detrimental to your health and your vision. Dilation opens the pupil to better evaluate eye health, but it does have these temporary side effects: Light sensitivity & blurred near vision that may last up to six hours. Please, only ever drive after any eye care visit with clear, comfortable vision. Pupil dilation is not typically performed at wellness eye exams for patients who are pregnant, nursing, or allergic to the dilating agents (proparacaine, phenylephrine/hydroxy-amphetamine hydrobromide, & tropicamide). Select which best represents your wishes:

- ○ NO dilation eye drops at this visit. If medically indicated, I shall schedule it to be done.
- ○ Discuss dilation with my doctor if medically indicated. This may add up to 30 minutes to your appointment.

Review of Systems

This section is updated verbally every visit but needs to be thoroughly completed just once so long as you maintain your established patient status by returning for your annual comprehensive eye exam each year.

Constitution

- ☐ None known
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other: _____

Respiratory

- ☐ None known
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other: _____

Integumentary

- ☐ None known
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex / Cold Sores
- ☐ Herpes Zoster / Shingles
- ☐ Other: _____

Ear / Nose / Throat

- ☐ None known
- ☐ Sinusitis
- ☐ Laryngitis
- ☐ Hearing Loss
- ☐ Dry Mouth
- ☐ Other: _____

Gastrointestinal

- ☐ None known
- ☐ Colitis
- ☐ Acid Reflux
- ☐ Other: _____
- ☐ Crohn's
- ☐ Ulcer
- ☐ Celiac Disease

Endocrine

- ☐ None known
- ☐ Type 1 Diabetes Mellitus
- ☐ Hormonal Dysfunction
- ☐ Type 2 Diabetes Mellitus
- ☐ Thyroid Dysfunction
- ☐ Other: _____

Neurological

- ☐ None known
- ☐ Epilepsy
- ☐ Tumor
- ☐ Migraine
- ☐ Other: _____
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Stroke
- ☐ Autism Spectrum Disorder

Genitourinary

- ☐ None known
- ☐ Prostate Disease / Cancer
- ☐ Pregnant or Nursing
- ☐ Chlamydia
- ☐ Kidney Disease
- ☐ Benign Prostatic Hypertrophy
- ☐ Herpes
- ☐ Other: _____

Hematologic / Lymphatic

- ☐ None known
- ☐ Large-volume blood loss
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Ulcer
- ☐ Other: _____

Psychiatric

- ☐ None known
- ☐ Attention Deficit
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Other: _____

Musculoskeletal

- ☐ None known
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Gout
- ☐ Arthritis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Other: _____

Allergy / Immunology

- ☐ None known
- ☐ Lupus
- ☐ Other: _____
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome

Cardiovascular

- ☐ None known
- ☐ Aneurysm
- ☐ Vascular Disease
- ☐ Other: _____
- ☐ Hypertension (high blood pressure)
- ☐ Heart Disease
- ☐ Congestive Heart Failure

Please list all allergies below; if you have no allergies circle: NKDA/NKMA

	Allergic to?	Reaction
1		
2		
3		
4		

Please list all current medications below; if you don't take any medications circle: NONE

	Medication	Dosage	Frequency	Reason for taking
1				
2				
3				
4				
5				
6				
7				
8				

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4SIGHT ICARE OFFICE POLICIES EFFECTIVE OCTOBER 2023 - please review each section carefully

NOTICE OF ANY PORTION DEEMED PATIENT RESPONSIBILITY BY THE PROVIDED INSURANCE CARRIER WILL BE BILLED TO THE PARTY LISTED HEREIN.

We respect our contractual obligations with all insurance and collect applicable copays and pre-determined patient responsibilities at the time of service. Medical insurance will generate an explanation of benefits to its member and the portion labeled "patient responsibility" will match the bill from our office or we will correct it. We will make every effort to discover any insurance plan for any patient but may not be able to reverse charges for services performed under the insurance carrier furnished by the patient. Unpaid balances may be subject to credit collection through a third party after 90 days of non-payment.

YOUR RESPONSIBILITY INCLUDING PAYMENT METHOD AND GOOD FAITH ESTIMATE

I, _____, am the responsible party for patient account: _____.

I authorize and request my insurance company pay directly to the doctor insurance benefits otherwise payable to me for any covered services that can be submitted to my carrier.

I acknowledge that whenever possible, medical insurance will be billed for medical office visits or medically coded examinations along with any associated procedures and that wellness visits will be billed to vision plans.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents, and if I choose to pay by credit card a secure offsite storage of my information may be used for future purchases or to pay any balance greater than 60 days from the date of service. 4Sight iCare believes strongly in the training and advancement of its team-members; the time spent providing me services has value and I understand that no product ordered at my doctor's office may be fully cancelled and/or refunded as these are professionals filling and dispensing prescriptions, not sales-persons selling commodities.

I understand that quotes for services and materials including glasses and contacts are made on a good faith basis, and that if insurance contributes more or less than the expected amount I may be notified of a balance due. Neglect of any amount due greater than 90 days from the invoice date may result in collections by a third party. Neglect to pick up any product greater than 90 days from its receipt at the office may result in a $40 shipping/storage charge; these funds are used to ship abandoned product to the address on file if approved for dispense - product not approved for dispense will be returned to the distributor without further recourse for retrieval of funds nor product by the party whom abandoned the product. Likewise, any bad check written, credit card transaction declined on a scheduled payment without immediate correction, or dispute of an appropriate credit card transaction will result in a $40 fee due at the time of each infraction.

The iHealth Wellness Exam is part of every annual comprehensive eye exam at 4Sight iCare; it has been

developed to help you SEE YOUR BEST for your lifetime. The doctor trusts his team to perform the proper examinations on each patient based on criteria designed to align with this mission. **Anyone may ask for a one-time financial hardship exception at checkout**, but the testing is performed by a technician whose job it is to collect as much data as possible to help the doctor provide you the best eye care. Below is a good faith estimate of the costs based on the most impactful criteria determining which tests will be performed: age of the patient.

The iHealth Wellness Exam performed at the Annual Comprehensive Eye Exam:

Ages 6-months to 3-years: Always $0. The Welch Allyn Spot Camera assists in accurate testing for eye alignment as well as vision in the developing eye, non-verbal patient, or anyone unable to use the machines with a chin and forehead rest; this equipment investment was so important to the doctor that he paid for the device out of his own funds so that every patient regardless of developmental status could achieve their best vision.

Age 4 and up: $58. 92250-52 ($39) Retina Photo, 92134-52 ($19) Retina Scan & 92025-52 ($0) Corneal Topography. Without -52 modifier for reduced service fee these expenses when ordered by the doctor are billable to medical insurance at $98, $82, and $44 respectively or $224 if ordered medically.

Age 14 and up: $78. All the tests performed on age 4 and up plus 99172-52 ($0) Contrast Sensitivity & 92082-52 ($20) Visual Field Test. When ordered medically, available for $58 and $44 respectively, or $326 if billable to medical insurance.

Additional testing at $0. 92700-52 ($0) Concussion Baseline and Saccadic Eye Movement Evaluation for ages 6 to 26. When performed outside an annual visit this ordered test is available for $58. Meibomian Gland Evaluation for all 18+.

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. **Get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests. **Ask us to limit what we use or share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with,

and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at the number listed above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/....** We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: 1) Share information with your family, close friends, or others involved in your care. 2) Share information in a disaster relief situation. 3) Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: 1) Marketing purposes. 2) Sale of your information. 3) Fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/....

Help with public health and safety. We can share health information about you for certain situations such as: 1) Preventing disease. 2) Helping with product recalls. 3) Reporting adverse reactions to medications. 4) Reporting suspected abuse, neglect, or domestic violence. 5) Preventing or reducing a serious threat to anyone's health or safety. **Do research.** We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies. **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you: 1) For workers' compensation claims. 2) For law enforcement purposes or with a law enforcement official. 3) With health oversight agencies for activities authorized by law. 4) For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/.... 6) Changes to the Terms of this Notice.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new one in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have reviewed the above rights, responsibilities, and disclosures with my signature:

_____	_____
Client Signature	Date