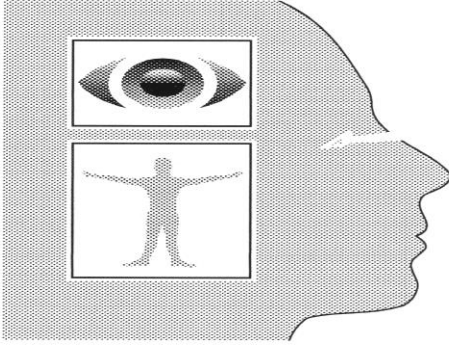


**Coastal Cape Fear Eye Associates, PA**  
OPHTHALMOLOGY / DISEASES AND SURGERY OF THE EYE



1915 Tradd Court  
Wilmington, NC 28401  
Telephone: (910) 762-0057  
Fax (910) 762-0336

8821 East Oak Island Drive Suite 3  
Oak Island, NC 28465  
Telephone: (910) 278-6400  
Fax (910) 278-4883

Website: <http://www.ccfear.com>

Patient Portal: <https://portal.ccfear.com>

**ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of Coastal Cape Fear Eye Associates, PA Notice of Privacy Practices

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I am a parent or legal guardian of \_\_\_\_\_

I have received a copy of Coastal Cape Fear Eye Associates, PA Notice of Privacy Practices effective September 23, 2013

Name (please print): \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 23, 2013 given to individual on \_\_\_\_\_

In Person  Mailing  Email  Other \_\_\_\_\_

Reason individual or parent/legal guardian did not sign this form:

Did not want to

Did not respond after more than one attempt

Other \_\_\_\_\_

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

Mailing \_\_\_\_\_

In person conversation \_\_\_\_\_

Telephone contact \_\_\_\_\_

Email \_\_\_\_\_

Other \_\_\_\_\_

Staff Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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