

Ohio Eye Associates

Notice of Bill of Rights and Advanced Directives Acknowledgement Form

Name: _____

Date: _____

Check and sign option one or option two below, please.

Option One:

_____ I have received a copy of Ohio Eye Associates Bill of Rights.
I also was given information concerning Ohio Eye's policy on advanced directives.
I am aware that I may request and receive official state advanced directive forms.

Option Two:

_____ I was offered a copy of Ohio Eye Associates Bill of Rights and
information on advanced directives, but did not want it.

Signature _____

For office Use Only:

A good faith effort was made to provide a copy of Ohio Eye Associates
Bill of Rights and information on advanced directives to this patient and to obtain his/her
acknowledgement of the same.

The patient _____ accepted _____ declined the information and refused to sign this
acknowledgement for the following reason: _____

Practice Representative: _____

Signature: _____ Date: _____