## EYE ASSOCIATES OF TEXAS

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## **ACKNOWLEDGMENT AND CONSENT**

I acknowledge that I have reviewed, understood, and consent to/agree to abide by the following practice policies:

	Initials:
Notice of Privacy	
Acknowledgement of Privacy Practices	
Financial Policy	
Consent to Treatment	
Patient Portal Access Consent	
Patient, Parent or Guardian Signature	Date
Patient Name (Please Print)	<del></del>