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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ___________________ DOB __/__/____ Relationship: __________
I acknowledge that Interventional Pain Associates provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient's name:
Date:
Signature:

Notice to patients:

You may or may not receive a prescription for medication on your first visit. By signing this policy you, the patient, acknowledge that you have read and understand its contents and agree to the terms.

Patient's name:
Date:
Signature: