THE SPINE + PAIN INSTITUTE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Account Number: _____

I hereby acknowledge that I received or was provided the opportunity to receive a copy of Akron General, The Spine & Pain Institute's Privacy Practices.

PATIENT INFORMATION:

Print Name: _____ Date: _____

Signature: _____ Phone #: _____

PERSONAL REPRESENTATIVE INFORMATION (if applicable):
Please fill out below if you want someone other than yourself to receive information on you.

Print Name(s): _____ _____

Nature of Relationship*: _____ _____
(*Parent, Guardian, Beneficiary, or Personal Representative of Deceased Patient, etc.)

Signature: _____ Date: _____

Please sign below if we may leave a voice message on your home, cell phone, or other phone with tests results or appointment information.

Cell phone: _____ Other phone: _____

☐ Yes, it is ok to leave message.

☐ No, please do not leave a message.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

☐ Signed form received. ☐ Acknowledgment not obtained.

☐ Patient refused. ☐ Emergency

☐ Other: _____

Staff Name (printed): _____

Staff Signature: _____ Date: _____ Time: _____