S.E. PA
PAIN MANAGEMENT

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices for **S.E. PA Pain Management, Ltd**.

Print Patient Name:_____

Signature of Patient: _____*

Date:_____

*If person signing is not the patient, please print your name and relationship to patient:

Name _____

Relationship _____

I [patient or representative] request a copy of the Notice of Privacy Practices: Yes ___ No ___

For Office Use:

If patient/representative requested copy of Notice, date copy was provided: _____

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment:

_____

_____

_____