CENTER FOR PAIN RECOVERY
Privacy Policy Acknowledgement

I have reviewed The Center for Pain Recovery's ***Notice of Privacy Practices*** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available at the front desk of The Center for Pain Recovery's lobby. I understand I am entitled to receive a copy of this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations of The Center for Pain Recovery. It also describes my rights and The Center for Pain Recovery's duties with respect to my protected health information.

My "protected health information" encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the practice's healthcare operations. The Center for Pain Recovery is not required to agree to the restrictions that I may request. However, if The Center for Pain Recovery agrees to a requested restriction, that restriction is binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Center for Pain Recovery has taken action in reliance on this consent.

The Center for Pain Recovery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I consent to the use or disclosure of my **protected health information** by **The Center for Pain Recovery** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations.

_____ _____
Signature of Patient or Personal Representative ***Date***

_____ _____
Printed Name of Patient or Personal Representative ***Signature of Parent if Patient is a Minor***

_____ _____
Description of Personal Representative's Authority ***Printed Name of Parent if Patient is a Minor***

Documentation of Good Faith Efforts

Patient Name _____ Date _____

The patient presented for his/her appointment or procedure on this date and was provided with a copy of The Center for Pain Recovery's Privacy Notice. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgment was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because: _____
- ❑ There was a medical emergency (The Center will attempt to obtain acknowledgment at the next available opportunity).
- ❑ Other reason, described below: _____

Signature of employee completing form: _____