Brain and Spine Center, PLC

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Brain and Spine Center, PLC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

Patient's Name (Print)_____Date of Birth_____

Patient's Signature_____Today's Date_____

FOR OFFICIAL USE ONLY

I, _____(BSC Employee), made a good faith effort to

obtain written acknowledgement of _____(Patient Name) receipt of the

Notice of Privacy Practices. However, I could not obtain written acknowledgement because:

□ Individual refused to sign this acknowledgement

□ Communications barrier prohibited obtaining written acknowledgement

□ An emergency situation prevented obtaining written acknowledgement

□ Other (please specify): _____

BSC Employee's Signature_____Today's Date_____