



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Bayou Pain and Spine is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information by our practice and outlines your rights with regard to your health information.

Please sign below to acknowledge that you have received our Notice of Privacy Practices.

Name: (Print Name): _____

Signature: _____ Date: _____

Bayou Pain & Spine (Print Name): _____

Signature: _____ Date: _____

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at this time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:
- Other _____

Bayou Pain & Spine (Print Name): _____

Signature: _____ Date: _____