

# Acknowledgement of Receipt of Notice of Privacy Practices

## Bakersfield Neuroscience & Spine Institute

2601 Oswell Street, Suite 101, Bakersfield, CA 93306

I hereby acknowledge that I have been provided with a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

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### For Office Use Only: Acknowledgment Tracking Information

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date patient received acknowledgement: \_\_\_\_\_ Staff Initials \_\_\_\_\_

*Complete the following only if the Patient refuses to sign the Acknowledgment. Document efforts to obtain.*

<u>Date</u>	<u>Explanation/Reason</u>	<u>Staff Initials</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____