The Center for Restorative Spine Surgery

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I was offered a copy of this Center's Notice of Privacy Practices and I have read and understand this information. I further acknowledge that a copy of the current notice has been posted in the Center for my review and that copies of any amendments to the Notice of Privacy Practices will be available at each future 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

Name and Address of Patient:

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