

\_\_\_\_\_  
Patient Name

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

**ACKNOWLEDGEMENT OF RECEIPT OF DESERT PAIN INSTITUTE'S  
NOTICE OF PRIVACY PRACTICES**

**\*You May Refuse to Sign This Acknowledgement\***

I have been allowed to review and/or have received Desert Pain Institute's Notice of Privacy Practices.

\_\_\_\_\_  
Today's Date: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature or legally authorized individual

\*\*\*\*\*

*For Office Use Only*

Desert Pain Institute could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- |   |  |
|---|--|
| <input type="checkbox"/> Individual refused to sign           | <input type="checkbox"/> An emergency situation prevented us |
| <input type="checkbox"/> Communication barriers prohibited it | <input type="checkbox"/> Other (please specify)              |

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date