Pain Management Associates • KC Pain Centers
A Division of Anesthesia Associates of Kansas City

# Acknowledgement of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our Notice of Privacy Practices is subject to change. If we change our Notice of Privacy Practices, you may obtain a copy of the revised Notice by visiting our website or request one from your health care team.

I acknowledge receipt of the Notice of Privacy Practices.

Signature: ____________________________________________ Date: _________________________________
(Patient, Parent, Conservator, Guardian)

Patient Name (Print): ___________________________________ Date of Birth: ___________________________

*** Any additional persons you would like for our office to have permission to speak to MUST BE listed below (re: Treatment, Medications, Test Results, etc.)

1. __________________________________________ __________________________________________
Name Relationship to Patient
2. __________________________________________ __________________________________________
Name Relationship to Patient
3. __________________________________________ __________________________________________
Name Relationship to Patient

Authorization for use of Automated Appointment Reminder System

I authorize Pain Management Associates to use an automated telephone system and/or electronic mail and to use my name, address and phone number; the name of scheduled treating physician; and, the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communications. I also authorize Pain Management Associates to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine.

☐Yes ☐No

Patient Signature: ____________________________________________ Date: ___________________________

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**Office Use Only**

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgment was not obtained:

Signature of Provider Representative: _____________________________________________ Date: _______________________

Reasons why the acknowledgment was not obtained:

☐Patient Refused to Sign

☐Other or Comments: _______________________________________________________________________________