325 Clyde Morris Blvd Suite 400
Ormond Beach, FL 32174
(386)671-0600 Phone (386) 677-9710 Fax

900N. Swallowtail Dr. Suite 102
Port Orange, FL 32128
(386)756-2223 Phone (386) 756-2115 Fax

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of Understanding of Advanced Pain Management's Privacy Practices

Patient's Name_____Date of Birth_____

Previous or other names used:_____Soc. Sec#_____

I understand that the patient's health information is private and confidential. I understand that the Dr. Kirit Bhalani and Dr. David Cummins referred to in this document as the physician's at Advanced Pain Management, work very hard to protect the patient's privacy and preserve the confidentiality of the patent's personal health information. Furthermore, I understand that the physician's at Advanced Pain Management may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment and to take care of other health care operations. [In general there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission – these situations are very unusual. An example would be if a patient has threatened to hurt someone.] **

The physician's at Advanced Pain Management have a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement and found on the website in the Patient Forms section. I understand that I have the right to read this "Notice" before signing this "Acknowledgement"

The physician's at Advanced Pain Management may update this Acknowledgement and Notice of Privacy Practices. If I ask the physician's at Advanced Pain Management to provide me with the most current Notice of Privacy Practices, they will do so. Within this Notice of Privacy Practices contains a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication be by specified methods of communications or alternative location.

The physician's at Advanced Pain Management have established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements and authorizations, reasonable time frames for requesting information, charges for copies and non-routine information needs, etc. I will assist the physician's at Advanced Pain management by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates that I have been given the chance to review a current copy of Advanced Pain Management's "Notice of Privacy Practices".

_____ _____ _____

Signature of Patient Date Time

_____

Relationship to Patient ~ if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

*** Bracketed sentence in the first paragraph is not required by HIPPA, but may be worth considering for the sake of more complete disclosure to the patient.*