Great Lakes Pain Management

Acknowledgment of Receipt of the Notice of Information Practices

We know you put your trust in us, so at Great Lakes Pain Management we are committed to abiding by all of the laws securing your privacy. As part of this commitment to you, we provided you with the opportunity to read our Notice of Information Practices. If you want a copy to keep, please do not hesitate to ask. By signing below you are acknowledging that you have had the opportunity to review our Notice.

We recognize that there may be situations in which someone other than you interacts with our office regarding payment. If you wish to designate other persons who may talk to our staff, please write their names below.

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Never hesitate to ask us about your treatment or about how we maintain your privacy.

Acknowledgement of Receipt of Privacy Policy

Phone Number___________________________

Patient Address____

Signature____Date___/___/____

If signing as a personal representative of the patient, describe the relationship and the source of authority to sign this form.

____________________________________ ____

Relationship to patient Print Name