NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Patient Name: _____

DOB: _____

Your signature below indicates that you have been offered a copy of SPO Notice of Privacy Practices.

Signature: _____ Date: _____
Patient Representative

Printed Name: _____ _____
Patient Representative Relationship to Patient

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FOR OFFICE USE ONLY:
SPO will make a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices provided to the patient. If the patient is unwilling or unable to sign this acknowledgment, SPO must document its good faith efforts to obtain such acknowledgments and record the reason why the acknowledgment was not obtained.

Reason: _____

Dallas Location
7777 Forest Lane, Suite C135
Dallas, TX 75230

McKinney Location
5236 W. University Drive, Suite 2900
McKinney, TX 75071

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