



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: _____
Patient Representative

Date: _____

Printed Name: _____
Patient Representative

Relationship to Patient

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

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(972) 347-4916 Fax

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