COLORADO CENTER FOR SPINE MEDICINE
4820 Riverbend Rd. 2nd Floor Boulder CO 80301
#303-444-2955 Fax# 303-889-5103

Name of patient: _________________________________ Date of birth ______________________

I hereby acknowledge that I am aware of the Notice of Privacy Practices (HIPPA) for CCSM and that a copy is available for my records.

So that the physician(s) and/or office staff may address privacy issues, please indicate with whom we may discuss your routine and/or emergent care and treatment:

Spouse: ____

Family Member(s): ____

Guardian: ____

Other: ____

Please initial below if you do not want physicians or staff to discuss medical care and treatment with anyone other than healthcare providers/representatives. _______

Please note that if there is question in regards to diversion, abuse, or misuse of medications, as dictated by Federal and Colorado State Laws, we must cooperate fully with Legal Authorities and Regulatory Agencies.

Patient or Representative Signature: __________________________________ Date:______________

Relationship of Representative: ______________________________________

FOR OFFICE USE ONLY

Documentation of Good Faith Effort to obtain patient's acknowledgement that they were made aware of the provider's Notice of Privacy Practices and could obtain a copy of the document.

The patient presented to the office on ________________ and was made aware of the Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her of the Notice. However, such acknowledgement was not obtained because (please circle below):

Patient refused to sign

Patient was unable to sign or initial because:____

Other Reason:____

Signature of employee completing form: ____ Date: ___________________