SOUTH TEXAS SPINAL CLINIC, P.A.

ACKNOWLEDGEMENT FORM

MR#: _____ PHYSICIAN: _____

PATIENT NAME: _____

DOB: _____ SSN #: _____

I acknowledge that South Texas Spinal Clinic, P.A. provided me with written copy of the STSC Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
STSC REPRESENTATIVE SIGNATURE DATE