

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES,
NARCOTIC POLICY AND MEDICATION POLICY
ISPINE SPORTS MEDICINE PAIN MANAGEMENT/ TAPMC**

I received a copy of the Notice of Privacy Practices, Medication Policy from the above noted entity.

Signature: _____

Date: _____

Print Name: _____

Personal Representative: _____

If personal representative, please note relationship to patient: _____

FOR OFFICE USE ONLY:

BY: _____

DATE: _____

SIGNATURE OF PATIENT: _____

PRINTED NAME: _____

DATE: _____