

PAIN MANAGEMENT ASSOCIATES • KC PAIN CENTERS

A division of Anesthesia Associates of Kansas City, PC

1300 East 104th St. • Suite 100

Kansas City, Missouri 64131

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices from Pain Management Associates.

Signature of Patient/Authorized Representative Date

Printed Name of Patient/Authorized Representative Date

If Authorized Representative, Relationship to Patient: _____

Witness Signature (if Authorized Representative signs for patient) Date

Unable to obtain acknowledgement of receipt of Notice of Privacy Practices because

PMA Staff member signature (if unable to obtain acknowledgement) Date

Authorization for use of Automated Appointment Reminder System

I authorize Pain Management Associates to use an automated telephone system and/or electronic mail and to use my name, address and phone number; the name of my scheduled treating physician; and, the time and place of my scheduled appointment(s), **for the limited purpose of contacting me to notify me of a pending appointment** or other healthcare related communications. I also authorize Pain Management Associates to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine.

Patient Signature Date