

**PAIN MANAGEMENT ASSOCIATES • KC PAIN CENTERS**  
4911 Arrowhead Dr., Suite 300  
Independence, MO 64455

**ACKNOWLEDGEMENT 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: \_\_\_\_\_

Unable to obtain acknowledgement of receipt of Notice of Privacy Practices because: \_\_\_\_\_

P/MA staff signature (if unable to obtain acknowledgement) \_\_\_\_\_ Date \_\_\_\_\_

**\*\*Any additional persons you would like to list for our office to have permission to speak to MUST BE listed below (re: treatment, medications, test results, etc.)**

1. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Name

2. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Name

3. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Name

**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 \_\_\_\_\_