



A SUBSIDIARY OF KINPEL MEDICAL, PC

**NOTICE OF PRIVACY PRACTICES RECEIPT ACKNOWLEDGMENT: Form to be signed by patient or representative to indicate he/she has received the privacy practices policy and understands its content.**

I, \_\_\_\_\_, acknowledge that I have received  
(Please print)  
and reviewed a copy of the SpinaTherapeutics™ Notice of Privacy Practices.

Name of patient if different than above:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Signature of patient or lawfully authorized representative:

\_\_\_\_\_ Date: \_\_\_\_\_