COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

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CPMS ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Comprehensive Pain Management's Notice of Privacy Practices. I have been advised that a copy of the current notice will be available any time that I arrive into the clinic and on our website at www.sdcpms.com.

_____ _____
Patient Name (printed) Patient DOB

_____ _____
Patient phone number Date

_____
Patient/Guardian Signature