Patient Name: _____

Date of Birth: _____

RIVERSIDE
PAIN PHYSICIANS

RIVERSIDE PAIN PHYSICIANS
RIVERSIDE SURGICAL CENTER

ACKNOWLEDGEMENT OF NOTICES

I acknowledge that I have received a copy of the following notices:

__X__ Patient's Bill of Rights and Responsibilities

__X__ Ownership Notice to Patients

__X__ Notice of Policy Regarding Advanced Directives

__X__ Privacy Practices / HIPAA

_____ _____

Patient's Signature Date

_____

Patient's Name Printed