Terrence L. Piper, M.D.
Christopher Hemmer, N.P

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received a summary of Piper Spine Care's Notice of Privacy Practices and consent to the use or disclosure of my protected health information by Piper Spine Care, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Piper Spine Care, P.C., and as required by law.

I also understand I may obtain a full version of the notice at any time, at my request. I understand my rights as a patient of this practice concerning my Protected Health Information (PHI), as it is outlined in this notice. I am aware Piper Spine Care, P.C. reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I understand that I can be updated on any changes by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

(Name of Patient or Personal Representative)

_____

(Signature of Patient or Personal Representative)

_____

(Date)

_____

(Description of Personal Representative's Authority)

Thank you for choosing Piper Spine Care, P.C.