SPORTS AND PAIN INSTITUTE OF NEW YORK

Melepura Medical Professional Corporation

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

Acknowledgement of Privacy Practice: I understand and have been provided with the practice's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider the practice's Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

NOTE: Please read the above agreements carefully and make sure that you understand all the terms and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above. Agreed and Accepted by:

_____	_____	_____
Patient's Signature	Patient's Name	Date
_____	__Febin Melepura, M.D.__	_____
Witness Signature	Witness Name	Date