Levi Pearson 111, MD, DABA, DAAPM

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Welcome to our practice. Please fill out the information below to the best of your ability.

PATIENT INFORMATION

Date: ____________________________

Name: ____________________________ DOB: __________ Age: ____ Sex: M/F Soc. Sec #: ____________________

Address:
___________________________________City:_________________________Stated:_________Zip:_______________

Home Phone: ______________________ Cell Phone: ______________________Email:_________________________

Occupation: _____________________________ Married______ Widowed _________ Single ________ Other______

Race:

___ American Indian or Alaska Native
___ Asian ___Other Pacific Island
___ Black or African American
___ Native Hawaiian ____ More than one race
___ White ____ Refused to answer

Ethnicity:

____Hispanic or Latino
____ Not Hispanic or Latino
____ refused to answer

Preferred Language:

____ English
____ Spanish
_____Other:

Meaningful use is the name of a new nationwide initiative to improve the health of our nation. As part of this initiative Metropolitan Pain and Spine. LLC is required to gather information for compliance with the Meaningful use guidelines. Part of this information includes adding patients' Race, Ethnicity and Preferred Language to our electronic medical record. The government requires we gather this information to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a national level. If you have additional questions please visit the office of the National Coordinator for Health Information Technology at www.health.hhs.gov and search Meaningful Use.

Metropolitan pain P.A/Spine	ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE FORM
Effective Date:	REFERENCED POLICY: NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices:

_X__ Paper
____ Electronic Mail

____
Print Patient Name

____
Signature if Individual Acknowledging NPP

____ Patient
____ Personal Representative
____ Healthcare Surrogate

____
Employee Witness

____
Date

FOR OFFICE USE ONLY

This Medical Practice was Unable to attain patient acknowledgment of the Notice of Privacy Practices explain below circumstances of the patient's refusal to acknowledge the Notice of Privacy Practices in the section provided below.

____

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Name of Employee	Employee Signature	Date