



ADVANCED ORTHOPAEDIC ASSOCIATES OF NORTH JERSEY, LLC  
*Diplomates/American Board of Orthopaedic Surgery*

## Acknowledgement of Receipt of Notice of Privacy Practices

*I acknowledge that I was provided a copy of the Notice of Privacy Practices  
For Advanced Orthopaedic Associates of North Jersey, LLC*

Patient Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date Signed: \_\_\_\_\_

\*\*If person signing is not the patient, please print your name here and tell your relationship to patient:

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I, \_\_\_\_\_ request a copy of the  
Notice of Privacy Practices.

Yes \_\_\_\_\_

No \_\_\_\_\_

=====

### **For Office Use:**

If patient/representative requested copy of Notice, Date copy was provided: \_\_\_\_\_

Given By: \_\_\_\_\_

If not, acknowledgement could be obtained, state reason why and the efforts taken to try to obtain

Acknowledgement: \_\_\_\_\_

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