NORTHFIELD SURGICAL CENTER, L.L.C.
741 NORTHFIELD AVE., SUITE 102, WEST ORANGE, NEW JERSEY 07052
973-243-1062

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt as of the date set forth below of a copy of the Center's "Notice of Privacy Practices."

________________________________ ________________________________
Printed name of patient **Patient's Date of Birth**

____
Signature of patient (or patient's personal representative)

Date____________

If a personal representative signs:

________________________________ ________________________________
Printed name of patient's personal representative

Relationship of personal representative to patient or personal representative's authority to act for the patient, if applicable

____
Date

Acknowledgment of Receipt of NPP (continued)

FOR CENTER USE ONLY (for use if Acknowledgement above is not signed)

____
Name of Patient

____
Name of Personal Representative
(if applicable)

☐ Date NPP provided/mailed _______________
By whom in Center: ______________________

If patient never signs the acknowledgment, complete information below:

Reason acknowledgement not obtained: (check applicable box)

☐ Patient/patient representative failed/refused to sign with no reason given.

☐ Patient/patient representative failed/refused to sign for following reason(s):

____
____
____

☐ Acknowledgment mailed/given but never returned to Center

☐ Other ____
____
____

______________________________ ______________________________
Signature of Center staff Date

kmjm2/19/03