



# The Orthopaedic Center

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## Notice of Privacy Practices

## Receipt Acknowledgement

The Orthopaedic Center, P.A. reserves the right to modify the privacy practices outlined in the notice.

I acknowledge that I have received a copy of the Notice of Privacy Practices for The Orthopaedic Center, P.A.

Name of Patient (please print) \_\_\_\_\_

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

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

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

(Required if the patient is a minor or an adult that is unable to sign this form.)

Relationship of Patient Representative to Patient: \_\_\_\_\_

(Spouse, Friend, Case Worker, Family Member, etc.)

**Thank You**