



**NPP ACKNOWLEDGEMENT**

**I acknowledge receipt of West Michigan Orthopaedics’  
NOTICE OF PRIVACY PRACTICES policy,  
which became effective on April 14, 2003.  
Revised September 23, 2013.**

\_\_\_\_\_  
*Print Patient’s Name*

\_\_\_\_\_  
*Patient’s Date of Birth*

\_\_\_\_\_  
*Signature (Patient / Personal Representative)*

\_\_\_\_\_  
*Relationship to Patient  
(if applicable)*

\_\_\_\_\_  
*Date of Signature*