Dear patient,

As required by privacy regulation mandated by HIPAA – Health Insurance Portability and Accountability Act, we are providing you with our Notice of Privacy Practices. We like to assure you we are fully committed to protecting your privacy.   Please acknowledge receipt of North Jersey Brain and Spine Center's Notice of Privacy Practices by signing your name below.

I acknowledge receipt of North Jersey Brain and Spine Center's Notice of Privacy Practices.

NAME__________________________________DATE_______________