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The undersigned certifies that he/she has received a copy of the Notice of Privacy Practices (HIPAA), and is the patient, or is duly authorized by the patient as the patient’s representative.

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Patient Signature (or Patient’s Representative)

Print Name

Date

Orthopaedic Surgeons
Joel S. Buchalter, M.D.
F.A.A.O.S., F.A.C.S.
Douglas J. Fauser, M.D.
F.A.A.O.S., F.A.C.S.
Win Chang, M.D.
F.A.A.O.S.
Lawrence G. Foster, M.D.
F.A.A.O.S.
Stuart T. Styles, M.D.
F.A.A.O.S.
Andrew M. Peretz, M.D.
F.A.A.O.S.
Victor Khabie, M.D.
F.A.A.O.S., F.A.C.S.
Michael L. Bernstein, M.D.
F.A.A.O.S.
Jeffrey H. Yormak, M.D.
F.A.A.O.S.
Scott Levin, M.D.
F.A.A.O.S.
Yariv Maghen, M.D.
F.A.A.O.S.

Rehabilitation Medicine
Interventional Pain Management
Nicholas R. Panaro, M.D.
D.A.B.P.M.R., F.A.A.P.M.R.
Jason Melnick, M.D.
D.A.B.P.M.R., F.A.A.P.M.R.
Dayna McCarthy, D.O.
F.A.A.P.M.R.

Rheumatology
Jean Y. Park, M.D.

Podiatry
Alan N. Berman, D.P.M.
F.A.C.F.A.S.

Physician Assistants/Nurse Practitioners
Andrew Kalmanson, RPA-C
Kara S. Lombardo, RPA-C
Carmine Spadaccini, RPA-C
Frank Fasano, RPA-C
Marci Saulnier, RPA-C
Nicole Martinelli, RPA-C
Lauren E. Laurelli, FNP-C

Practice Administrator
Betty Lander
blander@somersortho.com