ACKNOWLEDGEMENT OF RECEIPT AND REVIEW OF PRIVACY POLICY

I acknowledge and agree that I have received and reviewed the Office Privacy Policy for Melissa Sophia Joy, ND and that I understand its terms. I understand that if I have any question regarding any matter in the Privacy Policy that I can ask Dr. Joy regarding the same.

Date: _____

Patient Signature: _____

Patient Name: _____

ACKNOWLEDGEMENT OF RECEIPT AND REVIEW OF PRIVACY POLICY