Acknowledgement of Receipt

Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of nJoy Vision. We encourage you to obtain a copy at njoyvision.com/privacy-policy and review it carefully. Our Notice of Privacy Practices provides information about how we are allowed to use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised Notice at njoyvision.com/privacy-policy, at any nJoy Vision location, or by contacting us at 1-855-462-6569.

I authorize the release of my medical information to the following people:

☐ None

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Notice of Financial Practices

When necessary to process insurance claims for medical treatment or services rendered to me, I expressly authorize:

+ The release of any medical information about me by any holder of said information to any insurance carrier who may provide financial assistance for this treatment or service
+ The release to the Centers for Medicare and Medicaid and/or to the Health Care Financing Administration and its agent(s) of any medical information necessary to determine benefits
+ The payment by my insurance carrier(s) of insurance and/or Medicare benefits directly to nJoy Vision for services rendered.

I accept financial responsibility to nJoy Vision if my insurance does not pay for my services and/or the remaining balance(s) from what my insurance company has paid as discussed prior to the onset of my treatment.

I acknowledge receipt of the Notices of Privacy Practices and Financial Practices of nJoy Vision.

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printed name (patient / parent / conservator / guardian)

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signature **date**