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| --- | --- |
| **DATE:** (mm/dd/yyyy) |  |

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| **CLIENT INFORMATION** | | | | | | | | | |
| First Name | |  | | Middle Initial |  | | Last Name | |  |
| Sex | | M  F | | DOB (mm/dd/yyyy) | | | |  | |
| Diagnosis | Primary | |  | | | Secondary | | |  |
| Primary Email |  | | | | | Home Phone | | |  |
| Street Address |  | | | | | City | | |  |
| State |  | | | | | Zip and County | | |  |

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| **PARENTS/GUARDIANS (if patient not an adult or considered a dependent)** | | | |
| Parent Guardian Foster Parent | | | |
| Mother’s Name |  | Father’s Name |  |
| Mother’s Cell |  | Father’s Cell |  |

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| **INSURANCE INFORMATION (Please send up copies of card front and back as well.)** | | | | | | | | | |
| Name of Primary Insurance | | | | |  | | | | |
| Policy Holder |  | | | | | DOB (mm/dd/yyyy) | |  | |
| Policy Holder’s Social Security # | | | | | | |  | | |
| Policy Number | |  | | | | | Group Number | |  |
| Billing Address | | |  | | | | | | |
| Provider Services Phone | | | |  | | | | | |

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| Name of Secondary Insurance (If Applicable) | | | | |  | | | | |
| Policy Holder |  | | | | | DOB (mm/dd/yyyy) | |  | |
| Policy Holder’s Social Security # | | | | | | |  | | |
| Policy Number | |  | | | | | Group Number | |  |
| Billing Address | | |  | | | | | | |
| Provider Services Phone | | | |  | | | | | |

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| Name of Tertiary Insurance (If Applicable) | | | | |  | | | | |
| Policy Holder |  | | | | | DOB (mm/dd/yyyy) | |  | |
| Policy Holder’s Social Security # | | | | | | |  | | |
| Policy Number | |  | | | | | Group Number | |  |
| Billing Address | | |  | | | | | | |
| Provider Services Phone | | | |  | | | | | |

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| **AUTHORIZATION** | | | |
| I hereby authorize of any medical or other necessary information to My Heroes, llc. I also authorize payment of medical benefits to My Heroes, llc, and for services rendered. I further agree that should the amount be insufficient to cover the entire expense, I will be responsible for payment of the entire bill. | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

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| **CONSENT OF TREATMENT** | | | |
| I do hereby consent for treatment by My Heroes, llc, I consent to care and treatment that falls within the scope of physical, occupational and speech therapy practices as defined by the State of Georgia and/or Colorado. I understand that the practice of medicine, including physical and occupational therapy is not an exact science and that the treatment will involve physical participation on the part of the client which may involve risks of injury. I feel the possible benefits to myself, son, daughter or wards are greater than the risks assumed. I hereby, intending to be legally bound for myself, my heirs and assigns, executors or administrator, indemnify, hold hairless, waive release forever all claims for damages against My Heroes, llc, its board of directors, therapists, aides, volunteers and employees for any and all injuries and loses including theft, loss of property or death that I, my son, daughter or ward may sustain while participating in the My Heroes, llc program.  By signing this form, I acknowledge that I have read and understand the contents and am competent to execute it or if executed on behalf of another, that I am authorized to execute it on behalf of that person. | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

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| **EMERGENCY CONTACTS** | | | | | |
| Name |  | Relationship |  | Phone |  |
| Name |  | Relationship |  | Phone |  |

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| **PHYSICIAN INFORMATION** | | | | | | | | |
| Referring Physician | |  | | | Doctor’s Group | |  | |
| Address |  | | | | | City | |  |
| State |  | | Zip |  | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Primary Physician | |  | | | Doctor’s Group | |  | |
| Address |  | | | | | City | |  |
| State |  | | Zip |  | | | | |

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| Specialist | |  | | | Doctor’s Group | |  | |
| Address |  | | | | | City | |  |
| State |  | | Zip |  | | | | |

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| **CANCELLATION POLICY** | | | |
| **\*\*\*Consistent attendance is important to ensure your child’s optimal progress towards their therapy goals\*\*\***  Although we recognize that unanticipated conflicts sometimes arise in families’ schedules, we must maintain a policy of discharging clients following excessive cancellations or no-shows without prior notice. To ensure that our clinicians can most effectively plan their time to meet the needs of the patients they serve, parents/patients are asked to call My Heroes with any cancellations as far in advance as possible. Our voice mail is available 24 hours/day and therapists can be reached individually through email or telephone.  Every semester each family will be allowed (1) one unanticipated absence without charge per semester. This is to cover instances such as unexpected illness, car trouble, last minute trips of physician visits, etc. Families can attempt to make up this absence with their therapists within a **4-week period** based on the options their therapist can offer (there may also be opportunities to work in with a separate therapist if needed). If the missed session is made up within this time frame then the family will be offered another (1) one unanticipated absence without charge, and so forth. If the first absence is not made up ANY unanticipated absences beyond it will result in a full session charge.  --This does not include no-shows or missed sessions without communication, which will continue to incur a full charge regardless.  --As per our previous policy, any absences communicated at least two months in advance of an absence will be fully excused:)  --In the event of severe weather, construction, and other unforeseen circumstances that preclude the use of a horse in our therapy sessions, the expectation is that you/your child still come for a therapy session without the horse. If you choose not to attend on those days just be aware you will be charged for a full session.  To this end, please COMMUNICATE WITH YOUR THERAPIST to avoid any misunderstandings or confusion and LET US KNOW AHEAD OF THE SEMESTER if your family has any upcoming planned absences so we can account for them and coordinate them with Chastain. There is a ton of work and logistics (volunteers, horses, arena space, etc) that go into each and every session we hold and it's important that we all continue to be respectful of everyone's time and effort! | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

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| **CONSENT FOR RELEASE OF INFORMATION** | | | |
| I hereby authorize the following Person (s) or Facility (ies) to release information from the records of (you or your child here)  1) Person (s) or Facility (ies)  2) Person (s) or Facility (ies)  The information is to be released to My Heroes, llc and any of the therapists/employees working under the auspices of My Heroes, llc for the purpose of therapy services including any therapeutic riding and/or hippotherapy services provided under My Heroes, LLC.  **The release is valid for one year and can be revoked, in writing, at my request** | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

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| **PHOTO RELEASE** | | | |
| I hereby consent to and authorize the use and reproduction of any and all photographs and other audiovisual materials taken of me, my son, daughter or ward for promotional printed material and/or educational activities for My Heroes, LLC, Chastain Horse Park, LDT and PATH, Intl. | | | |
| I **DO** Consent to photo release. Patient/Parent/Guardian Signature |  | Date |  |
| I **DO NOT** Consent to photo release.  Patient/Parent/Guardian Signature |  | Date |  |

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| **PRIVACY PRACTICE AND PROCEDURES ACKNOWLEDGEMENT** | | | |
| I understand that My Heroes, LLC. may be provided access to, or create on my behalf, certain protected, indefinable, health information and that I have certain rights to the restriction of disclosure and use of such information. I hereby, acknowledge that on the date indicated below, I was presented with a copy of My Heroes, LLC. HIPAA Notice of Privacy Practices pursuant to HIPAA and 45 C.F.R. Parts 260 and 164 and applicable state law. I have reviewed the Notice and understand its terms or have been provided an opportunity to have the same explained to me. | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

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| **RELEASE OF INFORMATION** | | | |
| I hereby authorize My Heroes, LLC. to release to all insurance companies only such therapeutic and financial information as may be necessary to determine benefits entitled to and process payment claims for therapy services that will be provided. I hereby authorize My Heroes, LLC. to release to physicians and the Babies Can’t Wait Program therapeutic and financial information as may be necessary. | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

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| **CONSENT FOR PAYMENT** | | | |
| I understand the hourly rate for physical, occupational or speech therapy is $255.00/session at Chastain campus and $145 /session at Colorado State campus. I understand a yearly evaluation will be performed. I have read the above information regarding payment for therapy services by My Heroes, LLC. and fully understand this information. I authorize Brent Applegate, MPT, owner, or their billing agent, to bill my appropriate third party payer for direct reimbursement of therapy services rendered to my child. Benefit payment will be assigned directly to My Heroes, LLC. If payment is rendered to member, I will reimburse provider for amount paid and provide a copy of the accompanying Explanation of Benefits within two weeks of receipt. I understand that services will be put on hold, if I fail to reimburse member in a timely fashion. If I am uninsured, I will pay provider(s) in full prior to services being rendered. I will inform provider of any changes in applicable third party payer(s) that may occur. | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

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| **EMERGENCY MEDICAL RELEASE** | | | |
| In case of a medical emergency, the undersigned authorizes My Heroes, LLC and/or CHP, Ltd. to provide such medical assistance as they determine to be necessary. The undersigned authorizes any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the participant, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned. The undersigned hereby agrees to pay all fees and expenses of doctors, hospitals, ambulances, and other medical expenses reasonably and necessarily incurred. | | | |
| Patient/Parent/Guardian Signature |  | Date |  |

**YOU OR YOUR CHILD’S MEDICAL HISTORY IN YOUR WORDS**

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| **CLIENT MEDICAL HISTORY** | | | | | | | | | | | | | | | |
| First Name | |  | | | | Last Name |  | | | M.I. | | |  | DOB |  |
| Age |  | | Height | |  | | | | Weight | | |  | | | |
| Primary Physician | | | |  | | | | Phone # | | |  | | | | |

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| Abnormal Fatigue | Y N | Hydrocephalus | | Y N |
| Acute Arthritis | Y N | Incontinence | | Y N |
| Acute Herniated Disk | Y N | Indwelling Catheter | | Y N |
| Agitation with severe confusion | Y N | Loss of sensation | | Y N |
| Allergies dust, mold, hay, etc | Y N | Multiple Sclerosis, acute | | Y N |
| Aneurysm | Y N | Open wounds | | Y N |
| Arnold Chiari Malformation | Y N | Osteogenesis Imperfecta | | Y N |
| Audible Aspiration | Y N | Osteoporosis | | Y N |
| Cardiac/Heart condition | Y N | Obesity Problems | | Y N |
| Circulation problems | Y N | Recent Dorsal Rhizotomy | | Y N |
| Complete quadriplegia | Y N | Scoliosis greater than 30 degrees | | Y N |
| Degeneration of hip joint | Y N | Seizure disorder | | Y N |
| Diabetes | Y N | Shunt(s) | | Y N |
| Excessive swayback/hunchback | Y N | Spinal fusion | | Y N |
| Hip dislocation, subluxation, or dysplasia | Y N | Spondylolisthesis | | Y N |
| Grafts over bony/weight bearing areas | Y N | Silent Aspiration | | Y N |
| Head injury | Y N | Substance Abuse | | Y N |
| Hearing problems | Y N | Tethered Cord | | Y N |
| Hemophilia/Blood disorder | Y N | Unstable neck or spine | | Y N |
| Heterotrophic Ossification | Y N | Vision problems | | Y N |
| Food Allergies | Y N | If yes, to what? | | |
| History of skin breakdown | Y N | If yes, please explain | | |
| History of seizure (requires additional form) | Y N | If yes, please explain | | |
| Feeding tube | Y N | Other implanted medical device: | | |
| **SPECIFIC TO DOWN SYNDROME** | | | | |
| Negative cervical x-ray for atlantoaxial instability | | | Y N | |
| We are required to obtain an annual medical clearance from a licensed physician, which includes a neurological exam that specifically denies any symptoms consistent with atlantoaxial instability (AAI) that must be signed and dated by the physician. If your child has Down Syndrome, please request this form. | | | | |

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| **SURGICAL PROCEDURES** | | | | | |
| Surgery |  | Date |  | Hospital |  |
| Surgery |  | Date |  | Hospital |  |
| Surgery |  | Date |  | Hospital |  |

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| **BIRTH AND DEVELOPMENT** | | | | | | | | |
| Pregnancy | Full term | | | Premature | | | | |
| Delivery | Normal | | Cesarean | | Forceps | | Other (please describe) | |
| Were all milestones met on time? | | Y N | | | | If no, please explain | |  |

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| **LANGUAGE** | | | |
| Expressive language | | Within normal limits | Areas of concern |
| Receptive language | | Within normal limits | Areas of concern |
| How does the client communicate? | Gestures  Sounds  Pointing  Words  How many? (approx) | | |
| Does the client put 2-3 words together in phrase? Y N At what age did child say first word? | | | |
| How much does the client understand of what is being spoken to him/her? 100% 50-75% <50% | | | |
| Primary language: English  Other, which?       Secondary language: English  Other | | | |

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| **FEEDING** |
| Do you or your child have feeding issues? Y N If yes, please explain |

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| **GROSS MOTOR** |
| Do you or your child walk independently? Y N If applicable, type of assistive device: |
| Age your child sat       crawled       walked |

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| --- |
| **FINE MOTOR** |
| Do you or your child dress himself? Y N Do you or your child use utensils to eat? Y N |
| Do you or your child have difficulty writing? Y N, coloring? Y N,  cutting with scissors? Y N |

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| **GOALS/EXPECTATIONS** |
| What do you hope to achieve through our services? What goals would you love to see accomplished in: |
| 3 months? |
| 6 months? |
| 1 year? |
| Is there anything else you would like us to know about you or your child? |

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| **MEDICATIONS** | | | |
| **Name:** | **Dosage:** | **Frequency:** | **Reason:** |
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| **ANY PAST MEDICATIONS WE SHOULD BE AWARE OF** | | | |
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| **PREVIOUS TESTING** | | |
| **Test:** | **Date Tested:** | **Results:** |
| Hearing |  |  |
| Psychological |  |  |
| Vision |  |  |
| Swallow Study |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **SERVICES CURRENTLY RECEIVING** | | |
| **Service:** | **Frequency:** | **Contact/Therapist:** |
|  |  |  |
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| Do you have a current evaluation for any of the above therapies? Which one(s)?      Please send us recent reports if available. | | |

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| **RELEASE AND INDEMNIFICATION AGREEMENT** | | | |
| Whereas, My Heroes, llc., d/b/a Brent Applegate has made available to the undersigned, or to the child of the undersigned, or both, all or a portion of the property, equipment and facilities of My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado Sate University, or any other location, including but not limited to, riding areas, stables, equipment, and horses, the undersigned hereby assumes full responsibility for the safety of the Rider. The term Rider shall mean not only the undersigned, but also, any minor of the undersigned, and also any person who uses any portion of the property, equipment, horses or facilities of My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, with permission of the undersigned. Undersigned hereby releases My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, any landowner, their agents, employees, successors, assigns, legal representatives, heirs, executors and administrators from any and all claims, causes of action, demands, obligations and liabilities – which are now existing or hereafter mature or accrue at any time – arising out of or related in any fashion to Rider’s uses of My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, property, equipment or facilities, except for My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location gross negligence or My Heroes, llc. intentional acts. The undersigned acknowledges and fully understands that the Rider uses the property, equipment and facilities of My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location at his or her own risk. The undersigned hereby agrees to hold and save My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, any landowner, their agents, employees, successors, assigns, legal representative, heirs, executors and administrators harmless from each and every claim, demand, liability, or other obligation which may arise out of or be connected in any fashion with loss, injury or damage to the Rider or to the Rider’s property. The undersigned hereby agrees and covenants not to bring any action at law or in equity against My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, any landowner, their agents, employees, successors, assigns, legal representative, heirs, executors or administrators on behalf of the undersigned or on behalf of Rider, whether minor or adult, arising from or relating in any fashion to any injury, damage or other loss suffered by Rider and connected in any fashion with Rider’s use of My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, property, horses, equipment or facilities; and the undersigned shall further defend My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, any landowner, their agents, employees, successors, assigns, legal representative, heirs, executors and administrators against any such actions brought by Rider or on Rider’s behalf with respect to the Rider’s uses of My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location property, horses, equipment or facilities and the undersigned shall indemnify My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, their agents, officers, directors, employees, successors, assigns, legal officers, directors, employees, successors, assigns, legal representatives, heirs, executors and administrators for anything for which Rider is responsible either alone, jointly or severally. The undersigned herby acknowledges and understand that My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, their agents, employees, successors, assigns, legal representative, heirs, executors and administrators do not represent or warrant the quality or character of any horse furnished to Rider. Furthermore, the undersigned acknowledges and understand that horseback riding or other participation in activities at My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, may involve substantial risk of bodily injury, property damage and other dangers including, but not limited to, bodily injury or death resulting from kicks and bites, falling off horses or horses falling on Rider, being dragged by a foot caught in the stirrups, Rider being thrown by horse, equipment failure or collision with horses or vehicles or other inanimate objects. The term “Rider” shall also include: (Rider’s name here)  In the event Rider or any other the designated individuals is a minor, the undersigned, on behalf of said minor, does hereby consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or specific instructions of any physician or hospital. The undersigned acknowledges that this consent to treatment which may be required, but is given to encourage My Heroes, llc., Brent Applegate, Chastain Horse Park, LTD., Chastain Horse Park, Colorado State University, or any other location, any hospital staff and physicians to exercise their best judgment as to the requirements of such diagnosis or treatment. The undersigned hereby agrees to pay all fees and expenses of doctors, hospitals, ambulances and other medical expenses reasonably and necessarily incurred.  **READ CAREFULLY BEFORE YOU SIGN. THIS DOCUMENT RELEASES MY HEROES, LLC., BRENT APPLEGATE, CHASTAIN HORSE PARK, LTD., CHASTAIN HORSE PARK, COLORADO STATE UNIVERSITY, OR ANY OTHER LOCATION, FROM ANY LIABLITITY RESULTING FROM USE OF MY HEROES, LLC., BRENT APPLEGATE, CHASTAIN HORSE PARK, LTD., CHASTAIN HORSE PARK, COLORADO STATE UNIVERSITY, OR ANY OTHER LOCATION, PROPERTY, EQUIPMENT OR FACILITIES**  **WARNING: Under Georgia law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.**  **WARNING: Colorado - Warning -  Under Colorado Law, an equine professional is not liable for the  injury to or the death of a participant in equine activities resulting  from the inherent risks of equine activities, pursuant to section 13-21-119, Colorado Revised Statutes.** | | | |
| Rider Signature (Parent/ Guardian if rider is a minor) |  | Date |  |
| Witness Signature |  | Date |  |

**MY HEROES PAYMENT POLICY**

Payment for Physical, Occupational and Speech services through My Heroes, llc at Chastain Horse Park will be payable at $255.00 per session, the first four (4) of which will be due up front equal to $1020.00 and must be received prior to the initial evaluation visit.

As previously discussed, if you carry private insurance, your insurance will be billed in the same manner as before but reimbursements will be either be returned to you by My Heroes,llc, sent directly to your address as completed below, or credited toward future services. Thank you all and please let us know if you have any questions.

**\*\*Beginning April 1, 2021 all payments will be accepted through QuickBooks secured billing services. You will be sent an invoice to your email on file with a link to set up and pay using their secured server. You can use any credit or debit card you like, including HSA and FSA account cards. We keep no credit card information on file. Please let us know if this payment method does not work for you for any reason so that we can set up an alternative solution.**

**My Heroes, llc**

##### NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

• **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include providing a physical therapy session or the OT and PT discussing your care to coordinate treatment, etc.  
• **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your health plan for your therapy services.  
• **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.  
• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.   
• The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.   
• The right to request an amendment to your PROTECTED HEALTH INFORMATION.  
• The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.  
• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices, please contact:**

Owner/Therapist   
Brent Applegate, MPT  
316 S. Washington Ave  
Fort Collins, CO 80521  
678-984-7774

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
877-696-6775 (toll-free)

## Acknowledgment of Receipt of Privacy Practices

I,       have received a copy of My Heroes, llc. Notice of Privacy Practices with an effective date of April 14, 2021.

**Name of Patient**

**Name of Parent/Legal Guardian**

**Address of Patient/Parent/Legal Guardian:**

**Signature of Patient /Parent/ Legal Guardian:**

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**Name of Witness**

**Signature of Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**