# MyHeroes, LLC.

Overcoming Obstacles, One Hoof At A Time

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

| **CLIENT INFORMATION** | | | | | |
|---|---|---|---|---|---|
| First Name | | Middle Initial | | Last Name | |
| Sex | M☐ F☐ | DOB (mm/dd/yyyy) | | | |
| Height: | | Weight: | | Pronouns (optional): | |
| Diagnosis | Primary: | | Secondary: | | |
| Primary Email | | | Primary Phone | | |
| Street Address | | | City | | |
| State | | | Zip Code | | |

| **PARENTS/GUARDIANS** (if patient is not an adult or considered a dependent) | | | |
|---|---|---|---|
| Parent ☐ Guardian ☐ Foster Parent ☐ | | | |
| Parent Name | | Parent Name | |
| Parent Cell Phone | | Parent Cell Phone | |

| **INSURANCE INFORMATION** | | | |
|---|---|---|---|
| Primary Insurance | | | |
| Name of Primary Insurance | | | |
| Policy Holder | | DOB (mm/dd/yyyy) | |
| Policy Number | | Group Number | |
| Billing Address | | | |
| Provider Services Phone | | | |

Mailing Address: 316 S Washington Ave, Fort Collins, CO 80521
Service Address: 725 S Overland Trail, Fort Collins, CO 80521
brentapplegate@myheroestherapy.com

p) 678-984-7774
f) 888-551-6210
www.myheroestherapy.com

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| Secondary Insurance (If Applicable) | | | |
|---|---|---|---|
| Name of Secondary Insurance | | | |
| Policy Holder | | DOB (mm/dd/yyyy) | |
| Policy Number | | Group Number | |
| Billing Address | | | |
| Provider Services Phone | | | |

*Please note that Medicaid is the payer of last resort, meaning that if you or your child have primary commercial insurance, Medicaid will be your secondary insurance.*

| **EMERGENCY CONTACTS** | | | | | |
|---|---|---|---|---|---|
| Name | | Relation | | Phone | |
| Name | | Relation | | Phone | |

| **PHYSICIAN INFORMATION** | | | |
|---|---|---|---|
| **Referring Physician** | | | |
| Physician Name | | Doctor's Group | |
| Office Address | | | |
| Phone | | Fax | |
| **Primary Physician** | | | |
| Physician Name | | Doctor's Group | |
| Office Address | | | |
| Phone | | Fax | |
| **Specialist** | | | |
| Specialist Name | | Doctor's Group | |
| Office Address | | | |
| Phone | | Fax | |

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| SERVICES CURRENTLY BEING RECEIVED | | | |
|---|---|---|---|
| Service | Frequency | Therapist Name | Contact Information |
| | | | |
| | | | |
| | | | |
| | | | |

**YOU OR YOUR CHILD'S MEDICAL HISTORY IN YOUR OWN WORDS**

_____

_____

_____

_____

_____

| 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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| CLIENT MEDICAL HISTORY | | | | | |
|---|---|---|---|---|---|
| **Condition** | **Yes** | **No** | **Condition** | **Yes** | **No** |
| Abnormal Fatigue | | | Hydrocephalus | | |
| Acute Arthritis | | | Incontinence | | |
| Acute Herniated Disk | | | Loss of Sensation | | |
| Agitation with Severe Confusion | | | Multiple Sclerosis, Acute | | |
| Allergies | | | If yes, please list allergies: | | |
| Aneurysm | | | Open Wounds | | |
| Arnold Chiari Malformation | | | Osteogenesis Imperfecta | | |
| Audible Aspiration | | | Osteoporosis | | |
| Cardiac/Heart Condition | | | Obesity Problems | | |
| Circulation Problems | | | Recent Dorsal Rhizotomy | | |
| Complete Quadriplegia | | | Scoliosis Greater than 30 Degrees | | |
| Degeneration of Hip Joint | | | Seizure Disorder | | |
| Diabetes | | | Shunt(s) | | |
| Excessive Swayback/Hunchback | | | Spinal Fusion | | |
| Grafts Over Bony/Weight Bearing Areas | | | Spondylolisthesis | | |
| Head Injury | | | Silent Aspiration | | |
| Hearing Problems | | | Substance Abuse | | |
| Hemophilia/Blood Disorder | | | Tethered Cord | | |
| Heterotrophic Ossification | | | Unstable Neck or Spine | | |
| Hip Dislocation, Subluxation, or Dysplasia | | | Vision Problems | | |
| History of Skin Breakdown | | | If yes, please explain: | | |
| History of Seizure | | | If yes, please explain: | | |

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| SPECIFIC TO DOWN SYNDROME | | |
|---|---|---|
| All riders with Down Syndrome must be examined by a physician knowledgeable about Atlantoaxial instability (AAI). The exam must include full extension and flexion x-rays of the neck. The results of the x-ray and examination must demonstrate that the individual does not have the Atlantoaxial instability condition. The rider with Down Syndrome must also annually provide information from his/her physician clearly indicating the absence of neurologic symptoms by clinical exam. | | |
| Date of most recent x-ray and neurologic exam? (mm/dd/yyyy) | | |
| Negative cervical x-ray for atlantoaxial instability? | Yes | No |
| Neurologic symptoms of AAI present? | Yes | No |

| SURGICAL PROCEDURES | | | | | |
|---|---|---|---|---|---|
| Surgery | | Date | | Hospital | |
| Surgery | | Date | | Hospital | |
| Surgery | | Date | | Hospital | |
| Surgery | | Date | | Hospital | |

| MEDICATIONS | | | |
|---|---|---|---|
| Name | Dosage | Frequency | Reason |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| ANY PAST MEDICATIONS WE SHOULD BE AWARE OF |
|---|
| |

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| BIRTH AND DEVELOPMENT | | | | |
|---|---|---|---|---|
| Pregnancy | Full term ☐ | | Premature ☐ (if so, how many weeks?) | |
| Delivery | Normal ☐ | Cesarean ☐ | Forceps ☐ | Other (please describe) |
| Were all milestones met on time? | | Y ☐ N ☐ | If not, please explain. | |

| LANGUAGE | | |
|---|---|---|
| Expressive Language | Within normal limits ☐ | Area of concern ☐ |
| Receptive Language | Within normal limits ☐ | Area of concern ☐ |
| How does the client communicate? | Gestures ☐ Sounds ☐ Pointing ☐ Words ☐ Approximately how many? | |
| Does the client put 2-3 words together in a phrase? Y ☐ N ☐ | | Age of first word? |
| How much does the client understand what is being spoken to them? | | 100% ☐ 50-75% ☐ <50% ☐ |
| Primary language: | | |
| Secondary language (if applicable): | | |

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

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| PREVIOUS TESTING | | |
|---|---|---|
| **Test** | **Date Tested** | **Results** |
| Hearing ☐ | | |
| Psychological ☐ | | |
| Vision ☐ | | |
| Swallow Study ☐ | | |
| Other ☐ | | |

**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.**

| AUTHORIZATION | | | |
|---|---|---|---|
| I hereby authorize 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. | | | |
| Parent/Guardian Signature | | Date | |

| 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 Colorado. I understand that the practice of medicine, including physical, occupational , and speech 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 harmless, 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 losses 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. | | | |
| Parent/Guardian Signature | | Date | |

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## CANCELLATION POLICY

We realize that illnesses, emergencies, and other scheduling conflicts arise and are sometimes unavoidable. However, advanced notice allows us to fulfill other patient's scheduling needs and keeps the program operating at its most efficient level. Last minute cancellations have once again become an increasingly common concern among therapy and adaptive riding sessions, and starting on January 1, 2024, My Heroes will be implementing the following changes to our cancellation policy.

All policies will be effective on a semester-based session schedule:
- Fall Session: ~August 15 - December 31
- Spring Session: ~January 1 - May 15
- Summer Session: ~May 16 - August 14

Any known cancellations communicated ahead of the start of the semester will be fully excused, so please communicate with your therapist or program director as soon as possible!

| Cancellation Fee Schedule | | |
|---|---|---|
| | With 24hrs Notice | Without 24hrs Notice |
| 1st Cancel | No charge | No charge |
| 2nd Cancel | $35 | $90 |
| 3rd Cancel | $90 | $155 |
| No Call/No Show | $155 | |

All cancellation fees will be billed directly to the family or client, as My Heroes is unable to bill insurance, Medicaid, FSSP, or Medicaid waivers for these fees.

My Heroes reserves the right to cancel sessions in the event of unsafe conditions. We may cancel when Larimer County is on accident alert status or when weather or driving conditions have the potential to become dangerous. We may cancel classes in extreme heat (above 95 degrees or when the heat index reaches over 130), extreme cold (below 15 degrees), extreme winds, or dangerous thunder and lightning storms. We will make every effort to contact you in a timely manner if a cancellation is deemed necessary. Clients are responsible for supplying us a working, text-capable phone number so that we may contact you urgently.

If the client's assigned therapist is unable to make it to their scheduled appointment(s), My Heroes will try to find an alternate therapist or will try to reschedule the appointment if availability aligns with current openings. Cancellations fees do not apply if we are unable to accommodate the client with an alternate therapist or rescheduled appointment. If you or your child have any concerns with meeting the updated cancellation policies, please discuss a plan of action with your assigned therapist or the Program Director. We appreciate your understanding as we all navigate through these new policies.

| 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's name)_____ DOB:_____:

1) Person(s) or Facility(ies):

2) Person(s) or Facility(ies):

3) Person(s) or Facility(ies):

4) 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 information to be released is indicated below:

- Medical History
- Physical/occupational/speech therapy evaluation, assessment, and treatment plan
- Mental health diagnosis and treatment plan
- Individual Habilitation Plan (IHP)
- Classroom Individual Education Plan (IEP)
- Psychosocial evaluation, assessment, and treatment plan
- Cognitive-behavioral management plan
- Other relevant information pertaining to the client being treated at My Heroes, llc

The release is valid for one year and can be revoked, in writing, at my request.

| Parent/Guardian Signature | | Date | |
|---|---|---|---|

## 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, therapeutic and financial information as may be necessary.

| Parent/Guardian Signature | | Date | |
|---|---|---|---|

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## PHOTO RELEASE

I DO ☐
DO NOT ☐
consent to and authorize the use and reproduction by My Heroes, llc and/or the Temple Grandin Equine Center of any and all photographs and any other audio/visual materials taken of me or my child for promotional material, educational activities, exhibitions, social media use, or for any other use for the benefits of the above mentioned programs.

| Parent/Guardian Signature | | Date | |
|---|---|---|---|

## CONSENT FOR PAYMENT

Payment Policy: 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. 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.

I understand the hourly rate for physical, occupational or speech therapy is $155 /session at Colorado State University/Temple Grandin Equine Center. 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 me or my child. Benefit payment will be assigned directly to My Heroes, llc. If payment is rendered to a member, I will reimburse the provider for the 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 in a timely fashion. If I am uninsured, I will pay provider(s) in full for the services being rendered. I will inform the provider of any changes in applicable third party payer(s) that may occur.

| Parent/Guardian Signature | | Date | |
|---|---|---|---|

## 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, Colorado Sate University, Temple Grandin Equine Center, 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, Colorado State University, Temple Grandin Equine Center, or any other location, with permission of the undersigned. Undersigned hereby releases My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, any landowner, their agents, employees, contractors, 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, Colorado State University, Temple Grandin Equine Center, or any other location, property, equipment or facilities, except for My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, 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, Colorado State University, Temple Grandin Equine Center, or any other location at his or her own risk. The

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undersigned hereby agrees to hold and save My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, any landowner, their agents, employees, contractors, 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, Colorado State University, Temple Grandin Equine Center, or any other location, any landowner, their agents, employees, contractors, 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, Colorado State University, Temple Grandin Equine Center or any other location, property, horses, equipment or facilities; and the undersigned shall further defend My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center or any other location, any landowner, their agents, employees, contractors, 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, Colorado State University, Temple Grandin Equine Center, or any other location property, horses, equipment or facilities and the undersigned shall indemnify My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, or any other location, their agents, officers, directors, employees, contractors, 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, Colorado State University, Temple Grandin Equine Center, 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 understands that horseback riding or other participation in activities at My Heroes, llc., Brent Applegate, Colorado State University, Temple Grandin Equine Center, 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 include (Rider's name here)_____DOB:_____**

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, Colorado State University, Temple Grandin Equine Center, 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, COLORADO STATE UNIVERSITY, TEMPLE GRANDIN EQUINE CENTER OR ANY OTHER LOCATION, FROM ANY LIABILITY RESULTING FROM USE OF MY HEROES, LLC., BRENT APPLEGATE, COLORADO STATE UNIVERSITY, TEMPLE GRANDIN EQUINE CENTER OR ANY OTHER LOCATION, PROPERTY, EQUIPMENT OR FACILITIES**.

**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.**

| Parent/Guardian Signature | | Date | |
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## 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 crowns, fillings, teeth cleaning services, 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 dental plan for your dental 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.

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**For more information about our Privacy Practices, please contact:**
Owner/Therapist
Brent Applegate, MPT
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brentapplegate@myheroestherapy.com

**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)

## 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.

| Parent/Guardian Signature | | Date | |
|---|---|---|---|

## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ have received a copy of My Heroes, llc. Notice of Privacy Practices.

Name of Patient/Client/Rider:_____

Name of Parent/Legal Guardian:_____

Address of Patient/Parent/Legal Guardian:_____

| Parent/Guardian Signature | | Date | |
|---|---|---|---|