



MYHEROES, LLC.

OVERCOMING OBSTACLES, ONE HOOF AT A TIME

DATE: (mm/dd/yyyy)

CLIENT INFORMATION

First Name		Middle Initial		Last Name	
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	DOB (mm/dd/yyyy)			
Diagnosis	Primary		Secondary		
Primary Email		Home Phone			
Street Address		City			
State		Zip			

PARENTS/GUARDIANS (if patient not an adult or considered a dependent)

Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/>			
Mother's Name		Father's Name	
Mother's Cell		Father's Cell	

INSURANCE INFORMATION

Name of Primary Insurance			
Policy Holder		DOB (mm/dd/yyyy)	
Policy Holder's Social Security #			
Policy Number		Group Number	
Billing Address			
Provider Services Phone			

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			

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.		
Parent/Guardian Signature	<input type="text"/>	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 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 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 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.		
Parent/Guardian Signature	<input type="text"/>	Date

EMERGENCY CONTACTS				
Name		Relationship		Phone
Name		Relationship		Phone

PHYSICIAN INFORMATION				
Referring Physician		Doctor's Group		
Address			City	
State		Zip		

Primary Physician		Doctor's Group		
Address			City	
State		Zip		



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Specialist		Doctor's Group	
Address			City
State		Zip	

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 therapist can be reached individually through email or telephone.

Pre-planned absences (absences that we are made aware of prior to the semester start): completely excused; try to schedule makeups with your therapist

Absences reported prior to 24 hrs of sessions start time: Typically excused; please try not to make it a habit; once a semester is understandable given the amount of workload and commitments most parents or riders have on a day to day basis, >3 in a semester may indicate a problem and an alternate schedule or forfeiture of slot may need to be discussed. Please try to reschedule with your therapist.

Absences reported under 24 hrs of start time: excused only in event of real emergency or illness, again if this becomes habitual an alternate schedule or forfeiture of slot may need to be discussed. Otherwise a non-refundable charge of \$55 is assessed, which covers Chastain's fee, as by that time they have already put in the work to organize horses, arena time, volunteers, etc.

Absences under 3 hr prior to session start time or no-show absences: Full forfeiture of session fee, as by this point the therapist's time and Chastain's time and energies are fully devoted.

- Two no-shows are considered grounds for immediate discharge.
 - *****We encourage families to re-schedule cancelled sessions whenever possible.*** Speak with your therapist regarding availability to reschedule.**

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

Parent/Guardian Signature	<input type="text"/>	Date	<input type="text"/>
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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 program.

Parent/Guardian Signature	<input type="text"/>	Date	<input type="text"/>
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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.

Parent/Guardian Signature	<input type="text"/>	Date	<input type="text"/>
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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.

Parent/Guardian Signature	<input type="text"/>	Date	<input type="text"/>
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CONSENT FOR PAYMENT

I understand the hourly rate for physical, occupational or speech therapy is \$180.00/session at Chastain campus and \$160 /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.

Parent/Guardian Signature	<input type="text"/>	Date	<input type="text"/>
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EXCEPTIONS THAT WILL BE CREDITED OR MADE UP

- PLANNED ABSENCES AS DISCUSSED PRIOR TO SESSION
- SESSIONS CANCELLED BY THERAPIST FOR ANY REASON
- ONE UNPLANNED ABSENCE PER SESSION IS ALLOWABLE FOR FUTURE CREDIT OR MAKE UP LESSON

CLIENT MEDICAL HISTORY

First Name		Last Name		M.I.		DOB	
Age		Height		Weight			
Primary Physician				Phone #			

Abnormal Fatigue	Y <input type="checkbox"/> N <input type="checkbox"/>	Hydrocephalus	Y <input type="checkbox"/> N <input type="checkbox"/>
Acute Arthritis	Y <input type="checkbox"/> N <input type="checkbox"/>	Incontinence	Y <input type="checkbox"/> N <input type="checkbox"/>
Acute Herniated Disk	Y <input type="checkbox"/> N <input type="checkbox"/>	Loss of sensation	Y <input type="checkbox"/> N <input type="checkbox"/>
Agitation with severe confusion	Y <input type="checkbox"/> N <input type="checkbox"/>	Multiple Sclerosis, acute	Y <input type="checkbox"/> N <input type="checkbox"/>
Allergies dust, mold, hay, etc	Y <input type="checkbox"/> N <input type="checkbox"/>	Open wounds	Y <input type="checkbox"/> N <input type="checkbox"/>
Aneurysm	Y <input type="checkbox"/> N <input type="checkbox"/>	Osteogenesis Imperfecta	Y <input type="checkbox"/> N <input type="checkbox"/>
Arnold Chiari Malformation	Y <input type="checkbox"/> N <input type="checkbox"/>	Osteoporosis	Y <input type="checkbox"/> N <input type="checkbox"/>
Audible Aspiration	Y <input type="checkbox"/> N <input type="checkbox"/>	Obesity Problems	Y <input type="checkbox"/> N <input type="checkbox"/>
Cardiac/Heart condition	Y <input type="checkbox"/> N <input type="checkbox"/>	Recent Dorsal Rhizotomy	Y <input type="checkbox"/> N <input type="checkbox"/>
Circulation problems	Y <input type="checkbox"/> N <input type="checkbox"/>	Scoliosis greater than 30 degrees	Y <input type="checkbox"/> N <input type="checkbox"/>
Complete quadriplegia	Y <input type="checkbox"/> N <input type="checkbox"/>	Seizure disorder	Y <input type="checkbox"/> N <input type="checkbox"/>
Degeneration of hip joint	Y <input type="checkbox"/> N <input type="checkbox"/>	Shunt(s)	Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Spinal fusion	Y <input type="checkbox"/> N <input type="checkbox"/>
Excessive swayback/hunchback	Y <input type="checkbox"/> N <input type="checkbox"/>	Spondylolisthesis	Y <input type="checkbox"/> N <input type="checkbox"/>
Food Allergies	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, to what?	
Grafts over bony/weight bearing areas	Y <input type="checkbox"/> N <input type="checkbox"/>	Silent Aspiration	Y <input type="checkbox"/> N <input type="checkbox"/>
Head injury	Y <input type="checkbox"/> N <input type="checkbox"/>	Substance Abuse	Y <input type="checkbox"/> N <input type="checkbox"/>
Hearing problems	Y <input type="checkbox"/> N <input type="checkbox"/>	Tethered Cord	Y <input type="checkbox"/> N <input type="checkbox"/>
Hemophilia/Blood disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Unstable neck or spine	Y <input type="checkbox"/> N <input type="checkbox"/>
Heterotrophic Ossification	Y <input type="checkbox"/> N <input type="checkbox"/>	Vision problems	Y <input type="checkbox"/> N <input type="checkbox"/>
Hip dislocation, subluxation, or dysplasia	Y <input type="checkbox"/> N <input type="checkbox"/>		
History of skin breakdown	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, please explain	



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History of seizure	Y <input type="checkbox"/> N <input type="checkbox"/>	If yes, please explain
SPECIFIC TO DOWN SYNDROME		
Negative cervical x-ray for atlantoaxial instability	Y <input type="checkbox"/> N <input type="checkbox"/>	

Client Name		DOB	
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SURGICAL PROCEDURES					
Surgery		Date		Hospital	
Surgery		Date		Hospital	
Surgery		Date		Hospital	

BIRTH AND DEVELOPMENT					
Pregnancy	Full term <input type="checkbox"/>		Premature <input type="checkbox"/>		
Delivery	Normal <input type="checkbox"/>	Cesarean <input type="checkbox"/>	Forceps <input type="checkbox"/>	Other (please describe)	
Were all milestones met on time?	Y <input type="checkbox"/> N <input type="checkbox"/>		If no, please explain		

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

FEEDING
Do you or your child have feeding issues? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, please explain

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:

ANY PAST MEDICATIONS WE SHOULD BE AWARE OF			

PREVIOUS TESTING		
Test:	Date Tested:	Results:
Hearing <input type="checkbox"/>		
Psychological <input type="checkbox"/>		
Vision <input type="checkbox"/>		
Swallow Study <input type="checkbox"/>		
Other <input type="checkbox"/>		

SERVICES CURRENTLY RECEIVING		
Service:	Frequency:	Contact/Therapist:

Do you have a current evaluation for any of the above therapies? Which one(s)?



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OTHER PAYMENT OPTIONS

- I will be paying by credit card using the included cc authorization form, with all insurance reimbursement up to but not beyond the predetermined per session fee being returned or credited to me
- I will be paying by check or cash monthly 1 week prior to 1st of the month (I understand a late fee of \$25 will be incurred if payment is any later than 1 week prior to 1st of the month)
- My insurance will be covering the covering the sessions in full (I understand that I am responsible for all co-pays, deductibles, and unpaid treatments should insurance not reimburse ((My Heroes, llc will do everything possible and provide all requested documentation but cannot guarantee reimbursement by an insurance carrier)))

Rider/Parent/Guardian Signature

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Date

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.



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 hereby 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 APPLGATE, CHASTAIN HORSE PARK, LTD., CHASTAIN HORSE PARK, COLORADO STATE UNIVERSITY, OR ANY OTHER LOCATION, FROM ANY LIABILITY RESULTING FROM USE OF MY HEROES, LLC., BRENT APPLGATE, 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	



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MY HEROES RELEASE FOR PAYMENT

Payment for Physical, Occupational and Speech services through My Heroes, llc at Chastain Horse Park for the **Fall** session of 2015 will be payable at \$185.00 per session for the full fourteen (14) weeks equal to \$2590.00. Payment may either be remitted in one full lump sum (\$2590.00) or two equal payments of \$1295.00, the first of which must be received prior to the initial evaluation visit, the second of which will be due on **or before the 7th session in the semester.**

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.

AUTHORIZATION FOR CREDIT CARD PAYMENT			
Name on card:		Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> AX <input type="checkbox"/> Other <input type="checkbox"/>	
Exp date:		Card #	
CVV	Zip code on file for CC		
<input type="checkbox"/> Charge one time for full amount for full semester (14 weeks at \$185/session) = \$ 2590.00			
<input type="checkbox"/> Charge one time for 1 st or 2 nd half semester (7 weeks at \$185/session) = \$ 1295.00			
<input type="checkbox"/> Charge one time for full amount for hippotherapy sessions (at \$185/session) = \$			
For which session are you paying? <input type="checkbox"/> Summer <input type="checkbox"/> Fall <input type="checkbox"/> Spring What year			
I authorize My Heroes, llc to automatically debit/charge the above card for all agreed to payments in accordance with the attached, signed Payment Schedule/Payment Plan. (Keep a copy for your records) I understand that the information provided will be completely confidential and stored and locked in a secured/encrypted location.			
Rider/Parent/Guardian Signature			Date



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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 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



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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.



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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)



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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, 2013.

Name of Patient

Name of Parent/Legal Guardian

Address of Patient/Parent/Legal Guardian:

Signature of Patient /Parent/ Legal Guardian:

_____ **Date** _____

Name of Witness

Signature of Witness _____ **Date** _____