NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accounting Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- □ Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- □ Obtain payment from third-party payers.
- □ Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health care information. I understand that this organization has the right to change its Notice of Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of health care operation. I also understand you are not required to agree to my requested restrictions, but if you so agree then you are bound to abide by such restrictions.

I authorize my insurer to pay any benefits for services rendered directly to Madlena Performance Therapy. I understand that anything not covered by insurance is my full responsibility. I hereby authorize Madlena Performance Therapy through its appropriate personnel to perform on me, or the patient named below, appropriate assessment and treatment procedures relating to my diagnosis. This includes manual therapies including soft tissue release, joint mobilizations/manipulations, trigger point dry needling, therapeutic exercise and modalities. Benefits and risks will be freely discussed, and I fully realize that I may ask questions at any time, with my questions and concerns addressed immediately. I understand I will be fully informed on my evaluation findings as well as during each of my daily treatments. I understand that all therapies are being provided by licensed professionals in the State of Wisconsin.

Patient Signature: _____ Date: _____

Parent or Guardian (if minor): _____

**DUE TO FEDERAL PRIVACY RULES (HIPPA) we cannot speak to anyone other than yourself regarding your treatment or bill without your consent. Please indicate the person that you are authorizing us to release personnel protected information to:**

**_____ PERSON _____RELATIONSHIP**