

### **Acknowledgement Form**

I have read and understand the Notice of Information Practice and understand that TheraPro may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating quality of services provided and any administrative operations related to treatment of payment. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that TheraPro will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I have received a copy of the Notice of Patient Information Practices and hereby consent to the use and disclosure of my personal health information for purposes as noted in the Notice of Information Practices. I understand I retain the right to revoke this consent by notifying the Company in writing at any time.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature