NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996, also referred to as HIPAA, I have rights in regards to privacy, protecting my health information. I understand that the information provided can and will be used to:

- Assess, plan and treat as well as follow-up among the multiple healthcare providers collaborating directly or indirectly.
- Obtain payment from 3rd party payers
- Conduct normal healthcare operations such as quality assessments and therapists certifications.

I have received, read and understand your Notice of Privacy Practice containing a more detailed description of uses and disclosures in relation to my health information.

I understand that this organization has the right to change its Notice of Privacy and that I may contact Theraspeech, Inc. at any time to the address listed below to obtain a revised and current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out an assessment, treatment, payment or healthcare operations.

I understand that you are not required to agree to my requested restrictions; if you do agree, you are bound to abide by such restrictions.

Patient Name: ___________________________________

Guardian Name: _________________________________

Guardian Signature: ______________________________ Date: __________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practice Acknowledgement but was unable to do so as documented below.