OFFICE FINANCIAL NOTICE

AS OF JANUARY 1, 2010 THIS OFFICE REQUIRES YOU TO LEAVE A CREDIT OR DEBIT CARD ON FILE.

WE ACCEPT : VISA, MASTER CARD, DISCOVER AND CARE CREDIT

INSURANCE IS **NEVER** A GUARANTEE OF PAYMENT FOR SERVICES RENDERED.

IF YOU ARE UNABLE TO LEAVE A CREDIT OR DEBIT CARD ON FILE, YOU WILL BE EXPECTED TO PAY FOR ALL SERVICES RENDERED ON THE DATE OF SERVICE.

THIS PRACTICE DOES NOT SEND BILLS OR PATIENT STATEMENTS IN THE MAIL.

IF YOU HAVE QUESTIONS REGARDING THIS POLICY, PLEASE ASK THE RECEPTIONIST.

SHELDON FLEISHMAN D.P.M., P.A.

1050 South Outer Road
Blue Springs, MO 64015
816-228-9393

10701 Nall Avenue
Overland Park, KS 66211
913-381-5515

AUTHORIZATION FOR TREATMENT AND SERVICES, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND CHARGE TO MY CREDIT CARD.

I hereby authorize and accept medical treatment for myself and for my dependents as deemed necessary by Sheldon Fleishman D.P.M., P.A.. I also authorize Sheldon Fleishman and his officers, directors and his designated employees and agents to furnish information to insurance companies and other medical professionals regarding treatment and services provided to me and for my dependents, and regarding my medical condition and those of my dependents. I hereby assign to Sheldon Fleishman D.P.M., P.A. and to his employees all payments made for medical treatments and services provided to me or my dependents. I understand and agree that I am primarily responsible for the payment of all charges rendered by Sheldon Fleishman D.P.M., P.A.. I understand and agree for such medical treatments and services whether or not such charges are covered (either fully or partially) and paid (either fully or partially) by insurance.

I fully understand the policy of Sheldon Fleishman D.P.M., P.A., which is to secure an imprint of my credit card at the time of my initial office visit. If after a claim has been submitted to my insurance carrier(s), either the claim is denied for any reason or the charges are either not paid for or only partially paid by my insurance carrier(s), then in any of such events, Sheldon Fleishman D.P.M., P.A., will charge my credit card for the amount then, owing for medical treatment and services provided to me and my insurance carrier(s) subsequently makes payment to Sheldon Fleishman D.P.M., P.A. l, of all or a part of such charges, that Sheldon Fleishman D.P.M., P.A., will issue a credit in such amount received from my insurance carrier(s) to my credit card.

CREDIT CARD TYPE ____VISA ____MASTERCARD ____DISCOVER ____HSA
CREDIT CARD NUMBER_____
EXPIRATION DATE_____
NAME OF CARD HOLDER_____
NAME OF PATIENT_____
BILLING ADDRESS_____
_____
TELEPHONE NUMBER_____

I hereby authorize and direct Sheldon Fleishman D.P.M., P.A., and his designated agents and employees to process and charge my credit card the full amount of all charges made for medical treatments and services provided by Sheldon Fleishman D.P.M., P.A. I understand that the amount charged to my credit card will be reflected on my credit card statement. The amount charged will be based on the medical treatment and services rendered to me or my dependents as requested by me and the usual and customary charges made by Sheldon Fleishman D.P.M., P.A.

Notwithstanding the above, I hereby guarantee payment of all charges for medical treatments and services provided to me or my dependents by Sheldon Fleishman D.P.M., P.A., and agree that if Sheldon Fleishman D.P.M., P.A., places my account in the hands of a collection agency or an attorney for enforcement or collection in either such event, Sheldon Fleishman D.P.M., P.A., shall have the right to be paid back by me for all of his costs and expenses in collecting monies owed to them b y me for medical treatment and services provided to me to the extent not prohibited by applicable law. Those expenses include, for example, bu shall not be limited to, reasonable attorney's fees, court costs and other expenses incurred in connection with collection of my account by a collection agency or an attorney.

This authorization shall be and remain effective unless and until expressly revoked by me in writing and delivered to the office of Sheldon Fleishman D.P.M., P.A., unless an outstanding balance remains in which I am responsible to pay for before this policy may be revoked.

_____ _____
Signature of Patient/Responsible Party Date

PATIENT INFORMATION
(PLEASE PRINT)

NAME_____
First **MI** **Last**

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

HOME PHONE ( )_____ **CELL PHONE ( )**_____

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER**_____

GENDER: MALE / FEMALE WEIGHT_____ **HEIGHT**_____ **SHOE SIZE**_____

MARITAL STATUS_____ **OCCUPATION**_____

EMAIL ADDRESS:_____

EMPLOYER_____ **WORK PHONE**_____

EMERGENCY CONTACT/SPOUSE/PARENT/GUARDIAN (CIRCLE ONE)

NAME:_____ **PHONE**_____

EMPLOYER_____ **WORK PHONE**_____

REFERRED BY:_____

PREFERRED PHARMACY:_____

PRIMARY CARE PHYSICIAN_____
PHYSICIANS ADDRESS_____
OFFICE PHONE_____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION
I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO SHELDON FLEISHMAN, D.P.M., I AUTHORIZE RELEASE OF ANY AND ALL INFORMATION REQUIRED BY THE INSURANCE COMPANY FOR PAYMENT OF BENEFITS.

_____
PATIENTS SIGNATURE/PARENT **DATE**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE)AND UNDERSTOOD THE NOTICE.

_____
PATIENTS SIGNATURE/PARENT **DATE**

FINANCIAL RESPONSIBILITY
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL SERVICES PERFORMED BY DR. SHELDON FLEISHMAN, D.P.M.

_____
PATIENTS SIGNATURE/PARENT **DATE**

PATIENT MEDICAL HISTORY INFORMATION

(CONFIDENTIAL INFORMATION IMPORTANT FOR OUR FILES AND YOUR HEALTH)

1. STATE IN YOUR OWN WORDS YOUR MEDICAL REASONS FOR COMING TO OUR OFFICE:

_____

_____

2. HAVE YOU HAD AN UNUSUAL CHILDHOOD DISEASES SUCH AS POLIO OR SCARLET FEVER?

_____

3. PLEASE INDICATE "YES" OR "NO" IF YOU HAVE HAD SIGNIFICANT PROBLEMS IN THESE AREAS:

DIABETES_____ RECENT WEIGHT LOSS_____ THYROID_____ HEADACHES_____ CHEST PAIN_____
TROUBLE WITH VISION_____ TROUBLE WITH HEARING_____ HIGH BLOOD PRESSURE_____
CIRCULATION_____ HEART_____ SHORTNESS OF BREATH_____ TB OR PNEUMONIA_____
ASTHMA_____ ALLERGIES/HAYFEVER_____ RESPIRATORY_____ LIVER DISEASE_____
GALLBLADDER DISEASE_____ STOMACH TROUBLE_____ ANEMIA_____ ABNORMAL
BLEEDING_____SKIN_____ SWELLING OF THE FEET/ANKLES/LEGS_____

4. LIST ALL MEDICATIONS THAT YOU USE:

_____

_____

_____

_____

5. LIST ALL OPERATIONS THAT YOU HAVE HAD **SINCE** BIRTH:

_____

_____

_____

_____

6. PLEASE LIST AN ALLERGIES TO MEDICATIONS AND THE REACTION:

_____

_____

7. DO YOU HAVE A PROBLEM TAKING ASPIRIN:

_____

8. DO YOU SMOKE (CIRCLE ONE) YES NO IF YES, HOW MANY PACKS A DAY? _____

9. PLEASE INDICATE WHICH OF YOUR RELATIVES (BLOOD RELATED) HAVE HAD ANY OF THE FOLLOWING DISEASES:

DIABETES_____ CANCER_____ STROKES_____ KIDNEY DISEASE_____
ARTHRITIS_____ GOUT_____ HEART TROUBLE/HIGH BLOOD PRESSURE_____

10. **WOMEN ONLY:** ARE YOU PREGNANT? _____ IF YES, HOW MANY MONTHS_____

PATIENT SIGNATURE _____ **DATE**_____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
CUSTOM ORTHOTICS	Not a DMERC provider	$530.00
DIABETIC SHOES	No Diabetes Mellitus	$150.00
CAM WALKER	Not a DMERC provider	$175.00
RICHIE BRACE	Not a DMERC provider	$750.00
SURGICAL SHOE	Not covered by insurance	$ 38.00
ROUTINE FOOT CARE	Does not meet criteria	$ 90.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

SHELDON FLEISHMAN, D.P.M., P.A.
ASIM SAYED, D.P.M.

1050 NW South Outer Road
Suite 100
Blue Springs, MO 64015
(816) 228-9393

10701 Nall Avenue
Suite 120
Overland Park, KS 66211
(913) 381-5515

LIFETIME CONSENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Sheldon Fleishman, D.P.M., P.A. for any services furnished me that any physicians associated with the above mentioned practice. I authorize any holder of medical information about me to release to the Health care Financing Administration and its agents (Medicare) any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of patient **Patient's Medicare #**

_____

Date signed by patient

MEDICALLY UNNECESSARY RELEASE

_____ _____

Patient's Name **Patient's Medicare #**

I have been informed by the physicians of Sheldon Fleishman, D.P.M., P.A. that the services shown on my billing may be denied by Medicare Part B as medically unnecessary. I feel these services are necessary as prescribed by Dr. Sheldon Fleishman, D.P.M. P.A in the event Medicare should deny payment, I agree to be personally and fully responsible for payment to the physician.

Medicare usually does not cover "routine foot care", arch supports, or medical supplies for the feet.

_____

Patient's Signature

WE FILE ALL CLAIMS WITH ALL INSURANCE COMPANIES HOWEVER SOME DO NOT PAY FOR J3301 CODE WHICH IS USED WHEN AN INJECTION OF STEROID IS PREFORMED

THEREFORE, IT IS THE RESPONSIBILITY OF THE PATIENT FOR PAYMENT. THE COST OF THIS INJECTION IS $33.00.

IF YOU HAVE A CONCERN REGARDING THIS YOU WILL NEED TO CONTACT YOUR INSURANCE DIRECTLY.

PATIENT SIGNATURE:_____

DATE:_____

Sheldon Fleishman D.P.M., P.A.

Release of Medical Records/Information

Patient Name: _____ Date of Birth: _____

Persons to receive the information: _____

_____

Authorization will expire on : _____

Patient Signature: _____ Date: _____

Request for Confidential Communications

I request that all communications to be (by telephone, mail or otherwise) by Sheldon Fleishman D.P.M., P.A. and/or his staff be handled in the following manner:

For Written Communications: Address to: _____

_____

For oral Communications: Call: _____

(telephone number)

May we leave a detailed message?

Yes _____ No _____

Patient Signature: _____ Date : _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect <Insert date>, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make

repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you 25¢ for each page, $15.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your

request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Tiffany Nicole
(P) 913-381-5515 (F) 913-381-5514
10701 Nall Avenue #120
Overland Park, KS 66211