LINTECUM AND NICKELL, P.C.

Obstetrics and Gynecology

PATIENT INFORMATION SHEET

FOR OFFICE USE ONLY
PHYSICIAN: _____
PATIENT # _____

*****In order to contain costs, we expect payment in full at the time of service unless other arrangements have been made.*****

CELL #

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	SEX	DATE OF BIRTH	MARTIAL STATUS S M W D

ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY NO.	HOME PHONE NO.	OCCUPATION	WORK PHONE NO.

YOUR EMPLOYER | ADDRESS

SPOUSE'S NAME (OR PARENT) | SPOUSE'S (OR PARENT'S) DATE OF BIRTH AND SOCIAL SECURITY NO.

SPOUSE'S (OR PARENT'S) EMPLOYER | SPOUSE'S (OR PARENT'S) WORK PHONE

DR. REFERRED BY:

DRUG ALLERGIES

WHO SHOULD WE NOTIFY IN CASE OF EMERGENCY? (OTHER THAN SPOUSE)

NAME | PHONE NO.

ADDRESS | RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE CO.		**SECONDARY INSURANCE CO.**	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
GROUP NO.	ID NO.	GROUP NO.	ID NO.
INSURANCE COMPANY ADDRESS		INSURANCE COMPANY ADDRESS	
EMPLOYER	POLICY HOLDER	EMPLOYER	POLICY HOLDER

ATTENTION MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lintecum & Nickell, P.C. for any services furnished by that group. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE _____ DATE SIGNED _____

MEDICAL AUTHORIZATION AND PATIENT AGREEMENT

While I am here I permit the employees, the doctor, and all other persons caring for me to treat me in ways they are beneficial to me. I understand that the attending physician will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved. I also understand that he/she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment and no guarantees have been made to me about the outcome of this care.

I understand and agree that if my Employer, Workman's Compensation Carrier, or my Insurance Plan does not pay in full that I/we will be responsible for payment for all charges. I/we also agree that in the event of collection, I/we agree to pay all outstanding charges, costs of collection including reasonable attorney's fees. I hereby authorize Lintecum & Nickell, P.C., to release all information necessary to secure payment. I assign all benefits for unpaid services to which I am entitled to Lintecum & Nickell, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand and agree to the financial policy as stated above.

PATIENT'S SIGNATURE _____ DATE SIGNED _____

Family history questionnaire

Lintecum and Nickell, P.C.
Obstetrics and Gynecology

MyRisk™
Hereditary Cancer Test

Personal information

Patient name	Date of birth	Healthcare provider	Today's date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces** and **nephews** on both sides of the family. For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.

Do you have personal history of:	Yes(y)/no(n)	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have family history of:	Yes(Y)/No(N)	Maternal(M)/ Paternal (P)	Which relative?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N	☐ M ☐ P		
Two different breast cancers in one relative at any age	☐ Y ☐ N	☐ M ☐ P		
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N	☐ M ☐ P		
Ovarian cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Male breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Triple negative breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Pancreatic cancer at any age (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Colon cancer at 49 or younger (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Uterine cancer at 49 or younger (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Three colon and/or uterine cancers on the same side of the family at any age	☐ Y ☐ N	☐ M ☐ P		
Do you have family history of other cancers?	List them here:			
Have you or anyone in your family had genetic testing for hereditary cancer?	Who?		What gene?	Result?

Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature	Date
Healthcare provider signature	Date

Office use only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with MyRisk™ ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk™

☐ COLARIS®PLUS with MyRisk™ ☐ COLARIS AP®PLUS with MyRisk™ ☐ Single site testing ☐ MyRisk™ Update Test

☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

LINTECUM AND NICKELL, P.C.
MEDICAL HISTORY FORMS
HEALTH HISTORY

Pt # _____
Dr #_____

PATIENT NAME_____ **DOB**____/____/____ **AGE**_____

PREFERRED/NICK NAME_____ **PREVIOUS LAST NAME/MAIDEN NAME**_____

E-MAIL:_____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Reason for visit (please be specific)_____

VISIT DATE_____ When was your: Last physical exam?_____ Last pap? _____ Last mammogram?_____

1. PAST MEDICAL HISTORY & other hospitalizations – Have you ever had the following: **__No medical history to report**

	Date		Date		Date
__Abnormal Mammo	_____	__Gall Bladder	_____	__Osteoporosis	_____
__Acid Reflux	_____	__GI Disorder	_____	__Skin Cancer	_____
__Anemia	_____	__Heart Disease	_____	__Stroke	_____
__Anxiety Disorder	_____	__High Blood Pressure	_____	__Thyroid-overactive	_____
__Arthritis	_____	__High Cholesterol	_____	__Thyroid-under active	_____
__Bleeding Disorder	_____	__Joint Disorder	_____	__Trauma	_____
__Blood in Urine	_____	__Kidney Disorder	_____	__Urinary Incontinence	_____
__Cancer	_____	__Kidney Stones	_____	__Urinary Tract Infection	_____
__Convulsions	_____	__Liver Disorder	_____	__any other disease (please specify)	
__Depression	_____	__Lupus	_____	_____	
__Diabetes	_____	__Osteopenia	_____	_____	

Please list the name of your primary care physician and any other specialists you are currently seeing:_____
_____

2. PAST SURGICAL HISTORY – Have you ever had the following: **__ I have had no surgeries**
Please list all operations you have experienced and indicate year these occurred

□ Abdominal	_____	□ Hysterectomy	_____	□ Splenectomy	_____
□ Breast	_____	□ Knee/Foot	_____	□ Tonsillectomy	_____
□ Colonoscopy	_____	□ Laparoscopy	_____	□ Other Surgeries	_____
□ EGD	_____	□ Lumbar Disc	_____	□ Other Surgeries	_____

3. MEDICATIONS: Please list all **medicines** you are currently taking **__ I take no Medications**
(please continue on separate sheet)

CURRENT MEDICATIONS:	DOSAGE (mg)	How often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Please list all **ALLERGIES** (food, drugs, and environment) **__ I have no Allergies**

_____ _____
_____ _____

5. FAMILY HISTORY: Has any blood relative had any of the following: (Check box, leave blank if uncertain)

I have no family history of **__Breast Cancer** **__ Colon Cancer** **__ GYN Cancer**

	Relationship			Relationship
□ Heart Disease	_____	□	□ Stroke	_____
□ High Blood Pressure	_____		□ Genetic Problem	_____
□ Kidney Problem	_____	□	□ Mental Health	_____
□ Bleeding Disorder	_____	Type _____		
□ Cancer	_____	Type _____		
□ Diabetes	_____	Type _____		

Pt # _____

Dr #_____

6. GYN / MENSTRAL / SEXUAL HISTORY:

Age of 1st period _____ Do you have a period every month? Yes/No 1st day of last period _____

Days between period #_____ Total # days on period _____ Flow: □ Light □ Medium □ Heavy

How many days are heavy?_____ How many tampons/pads used on the heaviest day?_____

Spotting in between periods?_____ Method of Birth Control _____

Do you have… Headaches? Yes/No Cramps? Yes/No PMS? Yes/No Before or During period? (please circle)

Menopause Status: Pre / Peri / Post Age at Menopause _____

Have you ever had an abnormal Pap test? Yes/No Evaluation/treatment_____

Have you received HPV vaccine? Yes/No

Age of 1st intercourse _____ Have you had more than five (5) sexual partners in your lifetime? Yes/No

Have you had a bone density (patients over 50)? Yes/No

7. PREGNANCY:

Total pregnancy #_____ Full Term # _____ Premature #_____

Terminated # _____ Miscarriages # _____ Ectopic # _____

Multiple # _____ Living # _____

Pregnancy details: □ please continue on separate sheet

Date	Birth Wt	Sex	Type of delivery	Complications	Location

8. SOCIAL HISTORY:

Tobacco: ❑ never ❑ minimal ❑ yes (___packs/day x ___ yrs) ❑ quit ___yrs ago (___packs/day x ___ yrs)

Alcohol: ❑ never ❑ minimal ❑ less than 10 per week ❑ more than 10 per week

How much/how often do you exercise?_____

Illicit drug: ❑ No ❑ Yes what type: _____

Nutrition: Are you… Vegetarian? Yes/No Vegan? Yes/No Gluten Sensitive? Yes/No

How many servings (1/2 cup = 1 serving) of fruits/vegetables do you consume on a typical day? _____

Marital Status: ❑ single ❑ married ❑ widowed ❑ divorced ❑ partner

Occupation: _____

Name: _____ DOB: _____ Chart#: _____

Primary Care Physician (or nurse practitioner or PA): _____

Do you have periods? _____ First day of your last period/or reason you don't have periods:_____

Medications (or provide list):_____

_____

Reason for visit (**Please choose one**):

_____Annual Well-Woman Exam

-Please Note: **Insurance will not allow us to address significant problems (such as pain) at this visit.**

_____Repeat Pap

_____Routine Follow-up

-Your doctor asked you to schedule a visit to check on medications or a stable condition.

_____Pessary Insertion/Check

_____Pre-operative or Post-operative visit

-You have surgery scheduled –or– have recently had a surgery and are here for scheduled follow-up.

_____Postpartum Exam

-You had a baby about 6 weeks ago and are here for scheduled follow-up. (Also mark IUD placement if relevant.)

_____Procedure

-Such as a Biopsy, Colposcopy, LEEP, Hysteroscopy, IUD placement, Pessary Fitting/Insertion, Polyp, or Removal

_____Problem Visit

-Any other visit. Please fill out the next section in as much detail as possible.

_____Pregnancy

_____Talk

Please list anything you would like to discuss with your doctor:

-If you did not schedule this as a problem visit, **we may need to schedule another visit to address significant issues**, but please list them anyway. PLEASE be as detailed as possible.

_____

_____

_____

Nurse Notes:_____

_____

Please detail any significant problems you have had in the past year with: **None** ☐

General (e.g., fatigue, fever, night sweats): _____ ☐

Eyes (e.g., vision problems): _____ ☐

ENT (e.g., headaches, sinus congestion):_____ ☐

Breasts (e.g, lumps, tenderness, nipple discharge): _____ ☐

Heart (e.g., chest pain, palpitations): _____ ☐

Lungs (e.g., shortness of breath, cough, wheezing): _____ ☐

GI (e.g, nausea, diarrhea/constipation, loss of appetite):_____ ☐

Urinary: (e.g, urgency, blood in urine, incontinence):_____ ☐

Skin (e.g, rash, changes to moles, itching): _____ ☐

Neurological (e.g, speech difficulties, seizures): _____ ☐

Musculoskeletal (e.g, joint or muscle pain):_____ ☐

Endocrine (e.g, weight changes, hair loss, excessive urination or thirst): _____ ☐

Psychiatric (e.g, anxiety, depression, difficulty sleeping):_____ ☐

Heme/Lymph (e.g, easy bleeding/bruising, tender or enlarged lymph nodes): _____ ☐

Allergy/Immune (e.g, allergy symptoms, frequent illness):_____ ☐

Patient Signature: _____ Date: _____

Pt # _____
Dr #_____

Lintecum and Nickell P.C.
Obstetrics and Gynecology

Bronwyn Boyd, M.D. **Monica Franzen, M.D.** **Aubrey O'Connor, M.D.** **Joan Schieber, M.D.**

PROTECTED HEALTH INFORMATION

Please communicate with me in the following manner (**check all that apply**).

My primary contact number is: _____ Home Work Cell Other
- ❑ OK to leave a message with detailed information
- ❑ OK to leave a message with call-back number ONLY

My secondary contact number is: _____ Home Work Cell Other
- ❑ OK to leave a message with detailed information
- ❑ OK to leave a message with call-back number ONLY

My third contact number is: _____ Home Work Cell Other
- ❑ OK to leave a message with detailed information
- ❑ OK to leave a message with call-back number ONLY

Written Communication:
- ❑ OK to mail to my home address
- ❑ OK to e-mail: _____

My Primary Care Physician is: _____
My Primary Care Physician's Phone Number is: _____

❑ I do **NOT** have a Primary Care Physician at this time.

My Preferred Pharmacy is: _____
Pharmacy Phone Number is: _____
Pharmacy Location is: _____
(City) (State)

❑ I give permission for this office to confirm my medications with my pharmacies.

You may discuss my health care needs with the following individual(s)

Name of Individual	**Relationship to Patient**	**Phone#**
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

I understand that my primary or consulting doctor may need to request records from the physician I am seeing in the practice of Lintecum and Nickell. I also understand that my current insurance company may need to request records in order to pay for the claim that has been filed by the practice of Lintecum and Nickell. By signing this consent I am authorizing the release of those records to the physician or insurance company that is requesting them. This release expires 1 year from the date signed below.

Patient Signature: _____ **Date**: _____

Patient's Printed Name: _____ **Date of Birth**: _____

LINTECUM & NICKELL, P.C.
OFFICE AND FINANCIAL POLICY

EFFECTIVE 1/1/2024

Patient Name: _____ Patient number: _____

All patents must complete our Financial Policy and Patient Information forms **prior** to seeing the physician.

PLEASE NOTE: All appointment times are guidelines only. The physicians will spend as much time as needed to meet each patient's individual needs. This, as well as emergency cases and deliveries, can result in a delay in the daily schedules. We ask for your patience.

If you are more than 10 minutes late for your scheduled appointment time we reserve the right to not see you and reschedule your appointment.

YOUR INSURANCE INFORMATION AND PAYMENT RESPONSIBILITY: Please have your **current** insurance ID card available at each visit as well as a photo ID and current active credit card. We reserve the right to not see you if this information is not provided. It is your responsibility to inform our office of any changes.

The cost of medical care is determined by the nature and complexity of your visit. If you are here for an annual or wellness exam and problems are addressed then additional charges may apply or another scheduled visit may be needed. NON-emergent phone calls after hours may also result in a charge.

Your insurance plan is a contract between you and your insurance company. Our office makes every reasonable effort to obtain payment according to your coverage, it is the responsibility of you, the patient, to know and understand your insurance benefits as well as network status of your plan with our office as well as with St Luke's Hospital. Payment for services rendered is the responsibility of the patient whether your insurance pays or not. Our office also attempts to obtain accurate information from your insurance company for some procedures. If your insurance company does not provide accurate information and, subsequently, does not pay for services it is the responsibility of the patient to follow up with your insurance company regarding the unpaid claim. You, the patient, will ultimately be responsible for payment. We can also provide a good faith estimate for services provided, however, the actual dollar amount owed will be determined after the insurance adjudicates your claim.

CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND OUTSTANDING BALANCES: All co-payments are due at the time of check-in, prior to your appointment with the doctor. By law we are required to make efforts to collect deductibles, and co-insurance and/or co-payment obligations. In addition, by law, we are responsible to attempt collections of these amounts once they are identified to us on your explanation of benefits as patient responsibility amounts. All patient responsibility amounts are due 30 days from the date of the statement which will be sent to you after your insurance has adjudicated the claim. Any unresolved outstanding balances may be placed with an outside collection agency. If this occurs you, the patient, will be additionally responsible for all collection agency fees, court costs and reasonable attorney fees.

COLLECTIONS POLICY: If you or your minor child is turned over to our collection agency, you have **90 days** to set up a payment plan or clear your balance at the agency in full. If you have not set up a payment plan with the agency by 90 days, you will receive a notice of dismissal as a patient from our practice.

BANKRUPTCY POLICY: If Lintecum & Nickell, P.C. receives a notification of bankruptcy proceedings, and our charges have been included in your bankruptcy proceedings, you will receive a letter of discharge from our practice. Federal law states that you are unable to accrue charges, including medical expenses during this time, unless it is medically necessary.

PAYMENTS: We accept cash, personal checks, VISA, MASTERCARD, DISCOVER and AMEX. Please refrain from bringing bills larger than $20.00 as we are not a bank and do not have a large amount of cash in our office. Payment plans can be set up with our staff at the front desk.

RETURNED CHECKS: There is a $25.00 fee for all returned checks.

FORMS: There is a $40.00 fee for any forms that need to be filled out for you, your spouse, or your insurance company per completion. Examples include FMLA and disability forms. Payment will be required prior to the release of any forms. Please note there is a 7-10 business day completion time.

RELEASE OF MEDICAL RECORDS: Requests for release of medical records require written authorization by the patient. Authorization is not needed for requests from insurance companies, Federal agencies, or other medical professionals involved in the care of the patient. A fee is associated with all other records requests and must be paid prior to their release.

CREDIT CARD ON FILE: Lintecum & Nickell, P.C. requires a credit card to be placed on file for any and all balances that are over 30 days aged from the date of the current billing statement. These amounts will be placed on your card if payment has not been made or other payment arrangements have not been established with our practice within the 30 day window. This charge will occur with or without notification.

MISSED APPOINTMENTS: Any appointment that is not kept will be considered a “no show”. The time that was reserved for you, prevented another patient from receiving our service. For this reason a $40.00 fee will be assessed for the unused appointment time and will be charged to the card on file. Three “no shows” will result in dismissal from the practice.

AUTHORIZATION: I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company; therefore, I authorize my insurance company to pay directly to Lintecum & Nickell, P.C., and/or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collecting the amount, including collection agency fees, court costs, and reasonable attorney fees.

I authorize the physicians of Lintecum & Nickell, P.C. to administer care as necessary, including release of medical reports on my physical condition to any party involved in my treatment.

By signing below, I acknowledge and understand my financial responsibilities as a patient of Lintecum & Nickell, P.C.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Staff Member Date

Lintecum and Nickell, P.C.
Obstetrics and Gynecology
4320 Wornall Road Suite 720, Kansas City, MO 64111
Phone: (816) 531-2111 Fax: (816) 531-6025
E-mail: frontdesk@lintecumandnickell.com

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name:_____DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____What Doctor Do You See (Circle): Dr Boyd Dr Franzen
Dr O'Connor Dr Schieber

PLEASE COMPLETE THE FOLLOWING INFORMATION IN ORDER TO PROCESS YOU REQUEST

I WOULD LIKE MY MEDICAL RECORDS OBTAINED FROM:

Physician /Clinic/Self _____

Address _____

City/State/Zip _____

Phone:_____ Fax:_____

ARE YOU TRANSFERRING CARE? YES_____ NO_____

_____ ALL LAB RESULTS **_____ HIV TEST RESULTS**

_____ LAST 2 YEARS **_____ DRUG AND/ OR ALCOHOL ASSESSMENT/TREATMENT**

_____ ALL MEDICAL RECORDS * (PHYSICIAN APPROVAL _____)*

_____ RECORDS CONFINED TO THE FOLLOWING CONDITION_____

_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Guardian Signature: _____ Date: _____

Please Note: **Medical records are completed in the order in which they are received. Please allow 10 days for the processing of your request. This request expires in 60 days. This information has been provided to you from confidential records protected by state law. You shall make no disclosure of this information without the specific written and informed consent of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purposes of release of HIV test results or diagnosis.*

Lintecum and Nickell, P.C.
Obstetrics and Gynecology

4320 Wornall Road Suite 720, Kansas City, MO 64111
Phone: (816) 531-2111 Fax: (816) 531-6025
E-mail: frontdesk@lintecumandnickell.com

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name:_____DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ What Doctor Do You See (Circle): Dr Boyd Dr Franzen
Dr Lintecum Dr O'Connor Dr Schieber

PLEASE COMPLETE THE FOLLOWING INFORMATION IN ORDER TO PROCESS YOU REQUEST

I WOULD LIKE MY MEDICAL RECORDS RELEASED TO:

Physician /Clinic/Self _____

Address _____

City/State/Zip _____

Phone:_____ Fax:_____

ARE YOU TRANSFERRING CARE? YES_____ NO_____

REASON FOR TRANSFER: _____

_____ ALL MEDICAL RECORDS **_____ HIV TEST RESULTS**

_____ ALL LAB RESULTS **_____ DRUG AND/ OR ALCOHOL ASSESSMENT/TREATMENT**

_____ RECORDS CONFINED TO THE FOLLOWING CONDITION_____

_____

***There is a $28.70 base fee for medical records plus .66 cents per page. Pre-payment is required and must be received before records are mailed or faxed.**
Please make checks payable to Lintecum and Nickell

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

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I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Guardian Signature: _____ Date: _____

Please Note: **Medical records are completed in the order in which they are received. Please allow 10 days for the processing of your request. This request expires in 60 days. This information has been provided to you from confidential records protected by state law. You shall make no disclosure of this information without the specific written and informed consent of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purposes of release of HIV test results or diagnosis.*

Lintecum & Nickell PC

Authorization Agreement For Preauthorized Payments Policy

We require our patients to sign an Authorization Agreement for Preauthorized Payments by credit card or debit card.

To clarify and help you understand this policy, we offer this clarification:

- Following your medical visit and the filing of your insurance and subsequent payment from your insurance you will receive a statement from our office for any remaining balances deemed patient responsibility.

- It will show the date of services, description of services, exam charges, etc.

- It will also show what your insurance paid and what we adjusted (if we are contracted with your insurance).

- Upon receiving your statement, please contact our office immediately and inform us as to how you would like to pay your balance or remit payment. If payment is not received within 30 days of the date on the statement then the balance will be charged to the payment type on file.

- Example: “Please use my card on file” or “Do not use my card I will write a check” or “I need to set up a payment plan.

- <u>If you do not call, we will charge your payment type for the balance in accordance with your signed agreement.</u>

<u>YOUR SIGNED AUTHORIZATION</u>

<u>IS REQUIRED PRIOR TO</u>

<u>SEEING THE PHYSICIAN</u>

Lintecum & Nickell PC

Authorization Agreement
For Preauthorized Payments

This authorization is for the patient responsibility portion of your bill. For contracted insurance this will be the amount remaining after insurance payment and adjustment.

Patient Name _____ **Pt number** _____
(Please print) **(office use only)**

Card Holder name _____
(if different from Patient)

Type of Account (Please circle)

AMEX DISCOVER MASTERCARD VISA SIGNED CHECK

Credit Card# _____

Expiration date _____ **Security Code** _____

- I authorize Lintecum & Nickell PC to keep my signature on file, and to charge the credit card identified above for the balance of charges not paid by my insurance.
- I assign my insurance benefits to Lintecum & Nickell PC.
- I understand I should receive an Explanation of Benefits from my insurance company within 45 days of filing the claim showing the patient balance.
- I understand that when I receive my statement from Lintecum & Nickell PC showing my balance due, I must contact the office immediately to use a different form of payment, personal check, or payment plan and not use this authorization form. If payment is not received within 30 days of the date of the statement then the balance will be charged to the payment type on file.

Patient Signature _____ Date _____

Cardholder's signature _____ Date _____
(if different from patient)

LINTECUM & NICKELL, PC
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.

If you have questions about this notice or want more information, please contact: Privacy Officer at 816-531-2111. The effective date of this notice is October 15, 2015.

To appropriately treat you and receive payment for the services we provide, we need to obtain information from you including your full name and address, insurance company, family medical history, current medical history, and current medical condition. We will use and disclose this information and other information we collect in the ways described below. To help you understand how we will use and disclose your information we have put the different uses and disclosures into categories and give examples of each. All of the ways we use or disclose your information will fit into one of the categories listed below, but we cannot list all of the uses and discloses in each category.

We may use and disclose your health information for treatment, payment, and health care operations.

- **Treatment**. We may use and disclose your information to provide you with medical treatment and services. Your information may be disclosed to individuals and facilities providing care to you. These individuals and facilities need your information to provide care, and to coordinate and provide services (such as prescriptions, lab tests, meals, and x-rays).
- **Payment**. We may use and disclose your information to receive payment for the services and treatment provided to you. We use your information to create a bill and disclose your information when we send the bill to your insurance company, you, or a third party. The individual or entity paying the bill may request more information to determine whether the bill is covered by your insurance. We may tell your health plan about a treatment you are going to receive to get approval for payment or to determine whether your health plan will cover the treatment.
- **Health Care Operations**. We may use and disclose your information for health care operation purposes. Health care operations includes review of the care you receive for quality assessment, educational, business planning, and compliance plan purposes.
- **Appointment Reminders**. We may provide appointment reminders to you. You may request in writing that we send reminders to a confidential or alternative address.
- **Treatment Alternatives**. We may provide you with information about treatment alternatives and other health related benefits and services.

We may also disclose your health information to outside entities without your consent or authorization in the following circumstances:

- **Required by Law**. We disclose information as required by law. For example, we are required to report gunshot wounds to the police. We are also required to provide information to the Secretary of the Department of Health and Human Services to demonstrate our compliance with HIPAA.
- **Public Health Purposes**. We disclose information to health agencies as required by law for preventing or controlling disease. Examples are reporting of sexually transmitted, communicable, and infectious diseases.
- **To Prevent a Serious Threat to Health or Safety**. We may disclose information about you to law enforcement or an identified victim to prevent a serious threat to your health or safety or the health or safety of another individual or the public.
- **Research**. Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.
- **Health Oversight Activities**. Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.
- **Judicial and Administrative Proceedings**. We may be required to disclose your health information to a court or for an administrative proceeding.
- **Law Enforcement Activities**. We may be required to disclose your information as required by law, pursuant to a court order, warrant, subpoena, or summons.
- **Deceased Individual**. We may disclose information for the identification of the body or to determine the cause of death.
- **Military and Veterans**. If you are a member of the armed forces we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.
- **Organ and Tissue Donation**. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.
- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs.
- **Specialized Governmental Functions**. We may release information about you to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We will give you the opportunity to object to the following uses and disclosure of your information:

- **Individuals Involved in Care**. We may tell your friends, relatives and other caretakers information which is relevant to their involvement in your care.
- **Disaster Relief**. We may disclose information about you to public or private agencies for disaster relief purposes.

Except as provided above, we will obtain your written authorization prior to disclosure of your information for any other purpose. Specifically, written authorization is required prior to the disclosure of your information:

- **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without a written authorization except as specifically permitted by law.
- **Marketing**. We will not use or disclose your information for marketing purposes, other than face-to-face communications with you or promotional gifts of nominal value, without your written authorization.
- **Sale of Information**. We will not sell your PHI without your written authorization, including notification of the payment we will receive.

Where a disclosure is made under your written authorization, you have the right to revoke the authorization at any time. Revocation of an authorization must be in writing. The revocation is effective as of the date you provide it to Lintecum & Nickell, PC and does not affect any prior disclosures made under the authorization.

If a state or federal law provides additional restrictions or protections to your information, we will comply with the most stringent requirement.

Your Rights

You have the right to request a restriction on how information about you is used and disclosed. If you want to request a restriction of a use or disclosure of your information, contact our Privacy Officer at the number listed at the beginning of this form. We are required to agree to a request for a restriction related to disclosure of information to your health plan for payment or healthcare operations where you pay for the service in full. **We are not otherwise required to agree to any restriction on the use or disclosure of your information.**

You have the right to request communications with you be made at an alternative address or phone number. To request that communication be made at a different address or phone number contact our Privacy Officer at the number listed at the beginning of this form to obtain the form to make your request.

You have the right to inspect and copy your medical record. To inspect and copy your medical record a request must be made in writing on the form provided by Lintecum & Nickell, PC. To obtain a form contact our Privacy Officer at the number listed at the beginning of this form.

If you believe the information we have about you is incorrect or incomplete you may request that we amend your medical record. Your request must be made in writing on the form provided by

Lintecum & Nickell, PC. To request a form contact our Privacy Officer at the number listed at the beginning of this form.

You have the right to receive an accounting of disclosures, a list of individuals and entities that received your health information for reasons other than treatment, payment, or healthcare operations. You may receive one (1) free accounting during a twelve (12) month period. If you request more than one (1) accounting in a twelve (12) month period, you will be charged a fee. An accounting is not provided for disclosures prior to April 14, 2003.

You have the right to request a paper copy of this Notice.

Our Duties

We are required by law to maintain the privacy of PHI and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.

We are required to notify you if there is a breach of your unsecured PHI.

We are required to follow the terms of the current Notice.

We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted and a copy may be requested from our Privacy Officer at the number listed at the beginning of this form.

Complaints

If you believe your privacy rights have been violated you may contact:

Privacy Officer at 816-531-2111, 4320 Wornall Road, Suite 720, Kansas City, Missouri 64111 or the Office of Civil Rights. You will not be penalized for filing a complaint.

Lintecum and Nickell P.C.
Obstetrics and Gynecology

Bronwyn Boyd, M.D. **Monica Franzen, M.D.** **Aubrey O'Connor, M.D.** **Joan M. Schieber, M.D.**

I have received the Notice of Privacy Practices.

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Patient Signature Date