



6525 E Mainsgate Rd
Wichita, KS 67226
(316) 461-7923
fax 260-7045

Adult Intake Form

NAME: _____
First Name Middle Initial Last Name

DOB: _____ **AGE:** _____ **SS NUMBER:** _____ **GENDER:** Male Female

ADDRESS: _____ **APT.#:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____
Home Cell Work

E-MAIL ADDRESS: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER _____

PLEASE LIST ALL PERSONS (INCLUDING YOURSELF) CURRENTLY LIVING IN YOUR HOUSEHOLD.

	<u>NAME</u>	<u>RELATIONSHIP</u>	<u>DOB</u>	<u>AGE</u>	<u>OCCUPATION/YEARS OF EDUCATION</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

DESCRIBE YOUR FAMILY, CULTURE AND RELIGIOUS CONNECTIONS: _____

WHO REFERRED YOU TO US: _____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT: _____

IS TREATMENT COURT ORDERED? Yes No

SPIRITUALITY:

Would you describe your spiritual beliefs as producing: Comfort Stress N/A

Are you an active participant in a religious community? Yes No N/A

Would you like the counseling process to include:

Scripture discussion: Yes No

Prayer: Yes No

SELF/FAMILY MENTAL HEALTH HISTORY: (Please mark each that apply with "1" for self, "2" for immediate family, and "3" for extended family.)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> INDIVIDUAL THERAPY | <input type="checkbox"/> MARITAL THERAPY | <input type="checkbox"/> FAMILY THERAPY | <input type="checkbox"/> SEX THERAPY |
| <input type="checkbox"/> DOMESTIC VIOLENCE | <input type="checkbox"/> ANGER MANAGEMENT | <input type="checkbox"/> GROUP THERAPY | <input type="checkbox"/> GRIEF |
| <input type="checkbox"/> LOSS | <input type="checkbox"/> ANXIETY | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> BIPOLAR DISORDER | <input type="checkbox"/> EATING DISORDER |
| <input type="checkbox"/> PSYCHIATRIC HOSPITALIZATIONS | <input type="checkbox"/> SCHIZOPHRENIA | <input type="checkbox"/> ANTISOCIAL BEHAVIOR (HISTORY OF VIOLATING THE LAW) | <input type="checkbox"/> DRUG USE |
| <input type="checkbox"/> ALCOHOL USE | <input type="checkbox"/> OTHER SUBSTANCES | <input type="checkbox"/> OTHER ADDICTIONS | |

FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for self, "2" for immediate family, and "3" for extended family.)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> DENTAL PROBLEMS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> THYROID PROBLEMS | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> SEASONAL ALLERGIES | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HEAD INJURY |
| <input type="checkbox"/> HEARING ISSUES | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> OTHER |

CURRENTLY PRESCRIBED MEDICATIONS AND PRESCRIBING PHYSICIAN:

CURRENT GENERAL FUNCTIONING: (Please mark each that apply.)

- | | | |
|---|--|--|
| <input type="checkbox"/> CHEERFUL/HAPPY MOOD MOST OF THE TIME | <input type="checkbox"/> SAD OR TEARFUL MOST OF THE TIME | <input type="checkbox"/> FEELINGS OF HOPELESSNESS/EMPTINESS |
| <input type="checkbox"/> WITHDRAWN BEHAVIORS/ ISOLATION | <input type="checkbox"/> DIFFICULTY CONCENTRATING | <input type="checkbox"/> UNDER ACTIVE/SLUGGISH BEHAVIOR |
| <input type="checkbox"/> DECREASE IN INTERESTS/ACTIVITIES | <input type="checkbox"/> FEELINGS OF GUILT | <input type="checkbox"/> DOWN MOST DAYS |
| <input type="checkbox"/> DECREASED APPETITE | <input type="checkbox"/> INCREASED APPETITE | <input type="checkbox"/> WEIGHT GAIN |
| <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> NO ENERGY | <input type="checkbox"/> OVERLY FATIGUED DURING THE DAY |
| <input type="checkbox"/> SUICIDAL THOUGHTS | <input type="checkbox"/> SUICIDE ATTEMPTS | <input type="checkbox"/> INTENTIONAL SELF-HARM (I.E. CUTTING) |
| <input type="checkbox"/> POOR SELF-CARE/POOR HYGIENE | <input type="checkbox"/> POOR MEMORY | <input type="checkbox"/> EXTREME UPS AND DOWNS IN MOOD |
| <input type="checkbox"/> WORRY | <input type="checkbox"/> PANIC | <input type="checkbox"/> AVOIDANT |
| <input type="checkbox"/> STRESS | <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> ANGER |
| <input type="checkbox"/> TAKES MORE THAN AN HOUR TO FALL ASLEEP | <input type="checkbox"/> NIGHT WAKING FOR LONGER THAN 30 MINUTES | <input type="checkbox"/> HARD TO WAKE UP IN THE MORNING |
| <input type="checkbox"/> UNABLE TO SLEEP IN OWN BED THROUGH THE NIGHT | <input type="checkbox"/> FEARFUL OF PLACES, SITUATIONS OR PEOPLE | <input type="checkbox"/> FAST/RAPID SPEECH FEEL RESTED AFTER 3-4 HOURS SLEEP |
| <input type="checkbox"/> FEARLESS/ENGAGING IN RECKLESS ACTIVITIES | <input type="checkbox"/> EXAGGERATED VIEW OF ABILITIES | <input type="checkbox"/> LYING |
| <input type="checkbox"/> THREAT TO HURT SOMEONE WITH INTENT /PLAN | <input type="checkbox"/> PHYSICAL AGGRESSION | <input type="checkbox"/> CONFLICT WITH AUTHORITY FIGURES |
| <input type="checkbox"/> STEALING | <input type="checkbox"/> PHYSICAL CRUELTY TO ANIMALS | <input type="checkbox"/> PROPERTY DAMAGE |
| <input type="checkbox"/> VERBAL THREATS TO HARM OTHERS | <input type="checkbox"/> THOUGHTS OF HARM TO OTHERS | <input type="checkbox"/> INABILITY TO REMAIN SEATED |

- | | | |
|---|---|--|
| <input type="checkbox"/> EXPLOSIVE OUTBURSTS | <input type="checkbox"/> DISTINCT PERIODS OF NONSTOP ACTIVITY | <input type="checkbox"/> POOR SOCIAL SKILLS |
| <input type="checkbox"/> LEGAL PROBLEMS | <input type="checkbox"/> EXTREME CONFLICT WITH OTHERS | <input type="checkbox"/> GRADIOSITY-UNREALISTIC SENSE OF SUPERIORITY |
| <input type="checkbox"/> PROBLEMS WITH SCHOOL PERFORMANCE | <input type="checkbox"/> PROBLEMS WITH WORK PERFORMANCE | <input type="checkbox"/> INABILITY TO COMPLETE TASKS |
| <input type="checkbox"/> INABILITY TO SUSTAIN ATTENTION | <input type="checkbox"/> EASILY DISTRACTED | <input type="checkbox"/> OVERACTIVE/HYPERACTIVE |
| <input type="checkbox"/> IMPULSIVITY | <input type="checkbox"/> COMPULSIONS | <input type="checkbox"/> DENIAL |
| <input type="checkbox"/> NIGHTMARES | <input type="checkbox"/> SLEEPWALKING | <input type="checkbox"/> WETTING ACCIDENTS |
| <input type="checkbox"/> SEXUAL CONCERNS | <input type="checkbox"/> EXCESSIVE MASTURBATION | <input type="checkbox"/> PAIN DURING INTERCOURSE |
| <input type="checkbox"/> PROBLEMS WITH RELATIONSHIPS | <input type="checkbox"/> JEALOUSY | <input type="checkbox"/> BLENDED FAMILY |
| <input type="checkbox"/> DIVORCE | <input type="checkbox"/> MARITAL AFFAIR | <input type="checkbox"/> FAMILY CONFLICT |
| <input type="checkbox"/> MARITAL PROBLEMS | <input type="checkbox"/> TRUST | <input type="checkbox"/> ENABLING |
| <input type="checkbox"/> SHAME | <input type="checkbox"/> CRISIS | <input type="checkbox"/> CONCERNS WITH ELDER CARE |
| <input type="checkbox"/> CONCERNS WITH CHILD CARE | <input type="checkbox"/> DISABILITY | <input type="checkbox"/> EMPLOYMENT |
| <input type="checkbox"/> INTENTIONAL PURGING | <input type="checkbox"/> INTENTIONAL VOMITING | <input type="checkbox"/> HOARDING FOOD |
| <input type="checkbox"/> BINGE EATING | <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> BULIMIA |
| <input type="checkbox"/> OBESITY | <input type="checkbox"/> BODY IMAGE | <input type="checkbox"/> SELF-ESTEEM |

AUTHORIZATION AND CONSENT

By signing below you are authorizing Heritage Family Counseling Services to provide you with mental health services. (MUST BE SIGNED BEFORE SERVICES CAN BE PROVIDED)

Signature X _____ Date _____

BILLING INFORMATION: *If billing information is not complete and accurate, we reserve the right to **NOT** schedule additional appointments until it is supplied.*

PAYMENT OPTION: INSURANCE SELF-PAY OTHER _____

PRIMARY INSURANCE POLICY INFORMATION:

Primary Insurance Company: _____
Insurance Member I.D. Number: _____ Insurance Group Number (or none): _____
Effective Date: _____

PRIMARY INSURANCE INSURED PERSON INFORMATION:

Client's relationship to insured (i.e. self, spouse, child, other): _____
Insured Name: _____
Insured's Street Address: _____
Insured's City: _____ Insured's State: _____ Insured's Zip Code: _____
Insured's Phone Number: _____
Insured's Date of Birth: _____ Insured's Gender: Male Female
Insured's Employer: _____

By signing this agreement below you agree to and acknowledge each of the following conditions.

1. The information provided regarding insurance coverage is accurate.
2. Payment for any and all required co-payments, deductibles, coinsurance and non-allowable charges is required and due at the time the service is delivered. Payment must be in the form of cash, check or credit cards.
3. If your insurance company denies, refuses, or fails to make payments for the services rendered, Heritage Family Counseling Services will notify you in writing.
4. You assume responsibility for any and all fees rendered associated with services including document preparation fees provided at Heritage Family Counseling Services.
5. You will be solely responsible for the full cost of the session if you do not show up for your appointment or do not cancel at least 24 hours in advance.
6. Insufficient fund checks will be assessed a \$30.00 charge.
7. You are responsible for notifying Heritage Family Counseling Services of any changes in name, address, telephone number or insurance coverage.
8. By signing this agreement, you agree to allow Heritage Family Counseling Services to release any and all information necessary for filing insurance claims and collecting fees from your insurance company.
9. Heritage Family Counseling Services shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fees, and penalties and interest for the late payment or nonpayment thereof.

Print Name _____ Date _____

Signature X _____



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Informed Consent Agreement for Therapeutic Services

As a client(s) or parent of a client you and/or your child have certain rights and responsibilities. Those rights and responsibilities are outlined below. Each family member (13 years and above) in the client family should read and initial each blank on this form. Signing this form indicates acceptance of these terms for provision of services:

- ___ 1) You have the right to ask questions about your therapy. Your clinician will explain his/her therapy approach and methods used if you would like. Your clinician will also discuss the Code of Ethics under which he/she practices if you desire.
- ___ 2) You or your clinician have the right to end therapy at any time without any moral, legal or financial obligations other than those already incurred. We request that if the decision is made to terminate, that a final session be scheduled to explore the reasons for termination. If a final session is not scheduled your clinician may contact you to request feedback regarding termination. Termination itself can be a constructive and useful process. If a referral is desired, it will be made at this time.
- ___ 3) You have the right to specify and negotiate therapeutic goals and to renegotiate when necessary.
- ___ 4) You have the right to be fully informed about fees for therapy and the method of payment required.
- ___ 5) In order to communicate with insurance panels, it may be necessary to contact and share information regarding diagnosis, type of contact, frequency and duration of sessions with your specific provider.
- ___ 6) You have the right to confidentiality within certain limits. Information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency with the following exceptions:
 - a) you sign a written release of information indicating informed consent to such release;
 - b) you express serious intent to harm yourself or someone else;
 - c) there is evidence or reasonable suspicion of abuse against a minor child, elder person or dependent adult;
 - d) a subpoena or other court order is received directing the disclosure of information (it is our policy to assert privileged communication in such a situation);
 - e) you are in therapy or being tested by order of a court of law (the results of the treatment or test ordered must be revealed to the court); and
 - f) case consultation between the clinician and his/her clinical peers.
- ___ 7) You understand that suicide risk is to be taken very seriously. You want help in finding new ways to manage stress in times of crisis. You realize there are no guarantees about how crises resolve, and that your clinician is making reasonable efforts to maintain safety for everyone. You understand that in some cases hospitalization may be necessary.

- ___8) You have the responsibility to provide us with accurate information as to how we might best help you and to keep us advised of your needs throughout the therapeutic process.
- ___9) In working to achieve the potential benefits of therapy, it may require that you make firm efforts to change and it may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well relationship changes that may not be originally intended.
- ___10) Appointments are scheduled for 50 minutes, known as a “clinical” hour. The remaining 10 minutes on the “clock” hour is used by your clinician to maintain your file. Clients are expected to keep appointments as scheduled. **Because the appointment time is reserved for you, it is necessary to charge for appointments which are not canceled 24 hours in advance.** unless in fact they are occasioned by circumstances which we would both define as an emergency. You the client will be solely responsible for the full cost of the canceled or missed session. If you must cancel or reschedule, notify the clinician as far in advance as possible.
- ___11) You understand that all information is confidential according to HIPAA (Health Insurance Portability and Accountability Act) standards. Reception of HIPAA privacy practices and acknowledgement including verbal discussion of HIPAA expectations has taken place according to your initials.
- ___12) You understand the scope of practice of the assigned clinician. Discussion of your clinician’s experience and scope of practice as well as inability to perform surgery or prescribe medicine has taken place according to your initials.
- ___13) You understand that in case of your clinician’s death or incapacity to personally contact you, your clinician has identified _____ at _____ to have confidential access to properly contact you in order to either close and store your case file and/or to offer referral services to ensure continuity of care.
- ___14) Per the BSRB (Behavioral Sciences Regulatory Board) we are required to request permission or waiver to contact your primary care physician in order to consult with regard to your treatment received and related medical needs.
 _____ waive ___ or authorize to contact _____
 Physician’s Name/Number
- ___15) You understand that electronic communication through unencrypted text messages or email is not secure. It is our policy to not discuss therapeutic issues at length via text or email.
 ___ I authorize my clinician to communicate with me via text at this mobile number: _____
 ___ I authorize my clinician to communicate with me via email at this address: _____

_____ Client/Guardian Signature	_____ Date	_____ Client Signature	_____ Date
_____ Client/Guardian Signature	_____ Date	_____ Client Signature	_____ Date
_____ Clinician Signature	_____ Date		

NOTICE OF PRIVACY PRACTICES

Heritage Family Counseling Services

Julie Smith (316)992-6075, Privacy Officer

Effective Date: October 1, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

The individual clinician providing your behavioral health services collects health information about you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of the individual clinician (this medical practice), but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. Required by Law. As required by law, we will use and disclose your health information, but we will limit our

use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

7. **Public Health.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
8. **Health Oversight Activities.** We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
9. **Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
10. **Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
11. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
12. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
13. **Psychotherapy Notes.** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

B. Your Health Information Rights

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

C. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

D. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Frank Campbell, U.S. Department of Health and Human Services, 601 East 12th St, Room 353, Kansas City, MO 64106

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.