SILVERSTEIN EYE CENTERS P.C.

Steven M. Silverstein MD, FACS ▪ Timothy M. Stout MD ▪ Jeff L. Lookhart OD ▪ Suzanne R. Adkins OD

KANSAS CITY | INDEPENDENCE: 4240 Blue Ridge Blvd, Suite 1000 ▪ Kansas City, MO 64133 ▪ p: 816.358.3600 ▪ f: 816.358.1887

ODESSA: 201 N 2nd Street ▪ Odessa, MO 64076 ▪ p: 816.230.5321 ▪ f: 816.565.2288

Dear Patient:

Thank you for selecting Silverstein Eye Centers for your eye care needs. We are committed to providing quality eye care, and look forward to meeting you.

We have enclosed our medical history forms with the basic information needed for your medical records. Please bring the following information and forms with you:

- Photo ID
- New patient forms
- All current insurance cards
- If you wear glasses, bring them with you.
- List of your current medications- including the dosage. If you need to bring your medications in, make sure they are in the prescription bottle.
- Should your insurance carrier require a referral or an authorization, please bring that with you.

Your first visit with Silverstein Eye Centers will consist of a comprehensive eye exam; it will take approximately 2 to 3 hours. If additional testing is done, your appointment may be longer.

Your eyes may be dilated during this visit. We recommend you bring a pair of sunglasses to protect your eyes from the sun. You may want to have someone with you to drive you home.

Appointment Date: _____ Appointment Time: _____ am. | pm.

Your appointment is scheduled with:

❑ Steven M. Silverstein MD, FACS ❑ Timothy M. Stout MD ❑ Jeff L. Lookhart OD

Located at **4240 Blue Ridge Blvd, Suite 1000,** of the Blue Ridge Tower Building.
(816) 358-3600

❑ Suzanne R. Adkins OD, FAAO

Located at **201 N 2nd Street, Odessa, MO.**
(816) 230-5321

A map is attached with our addresses and telephone numbers. For patients with mobility challenges with ambulating or transferring to an exam chair, please inform our staff prior to your visit.
We look forward to seeing you.

GREATER KANSAS CITY / INDEPENDENCE OFFICE / 816.358.3600

4240 Blue Ridge Blvd, Suite 1000, Kansas City, MO 64133
Our office is located on the
10th floor of the
Blue Ridge Tower Building.

Take I-70 to Blue Ridge Blvd. (EXIT 11)
At the bottom of the exit ramp, turn **south** onto 40 Hwy.
Proceed approximately 1 block and turn **right** into the Walmart entrance.

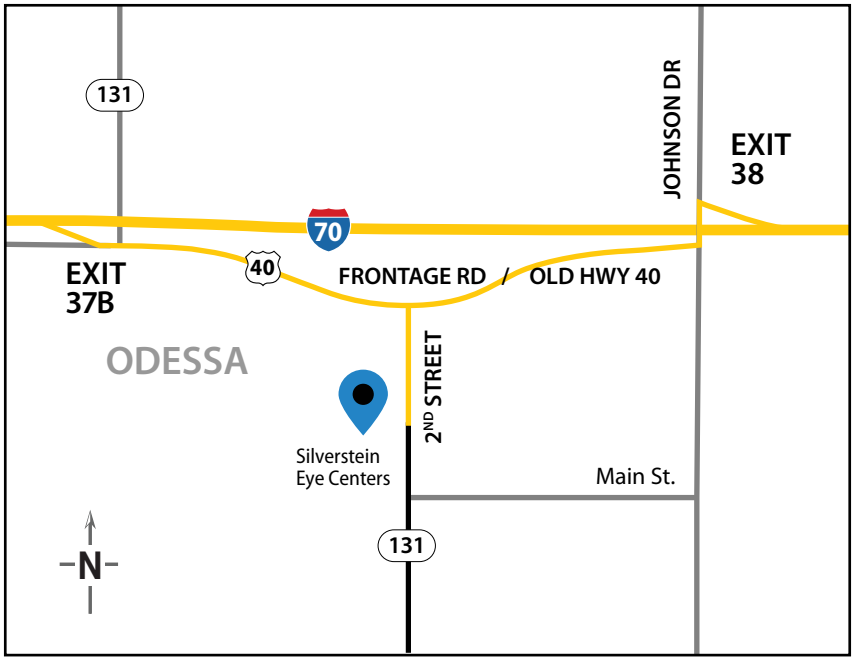
Then **left** to the Blue Ridge Tower Building.

THE ODESSA, MO LOCATION / 816.230.5321

201 N 2nd Street, Odessa, MO 64076

If heading East on I-70:
Exit 37B toward Odessa,
continue straight on the outer road.
Turn **right** onto 131 highway.
Destination will be on the **right**.

If heading West on I-70:
Exit 38 toward MO-131 S/Odessa
Turn **left** onto Johnson Dr.
Turn **right** at the 1st cross street
onto I-70 Frontage Rd/Old Hwy 40
Turn **left** onto 131 highway.
Destination will be on the **right**.



SILVERSTEIN EYE CENTERS P.C.

4240 Blue Ridge Blvd, Suite 1000,
Kansas City, MO 64133

201 N 2nd St
Odessa, MO 64076

PATIENT INFORMATION

Name _____ Today's Date _____

Preferred Name _____

Date of Birth ____/____/_____ SS# ___ ___ ___ – ___ ___ – ___ ___ ___ ___ ◯ Male ◯ Female

Address _____ City _____ State _____ Zip _____

Phone Numbers Home ( ) - Cell ( ) -

Work ( ) - E-mail _____

Occupation _____ Employer _____

Preferred Language:
◯ English
◯ Other: _____

Race:
◯ American Indian / Alaska Native ◯ Black or African American
◯ Asian ◯ White ◯ Native Hawaiian / Other Pacific Islander

Ethnicity:
◯ Hispanic / Latino
◯ Not Hispanic / Latino

Emergency Contact: _____ Numbers: ( ) - or ( ) -

Insurance

Guarantor (Financially Responsible Party)

Name _____ ◯ Self ◯ Spouse ◯ Parent ◯ Other: _____

Primary Insurance _____ Policy Holder _____

Policy ID # _____ SS# ___ ___ ___ – ___ ___ – ___ ___ ___ ___ Insured Date of Birth ____/____/_____

Secondary Insurance _____ Policy Holder _____

Policy ID # _____ SS# ___ ___ ___ – ___ ___ – ___ ___ ___ ___ Insured Date of Birth ____/____/_____

Vision Plan Insurance _____ Policy Holder _____

Policy ID # _____ SS# ___ ___ ___ – ___ ___ – ___ ___ ___ ___ Insured Date of Birth ____/____/_____

Reason for today's visit

◯ Routine eye exam ◯ Medical (cataracts, diagnosis of diabetes, glaucoma, macular degenerative disease, dry eyes)

_____

Referral

How did you hear about our office?

I was referred by: ◯ My doctor: Name _____ Phone ( ) -

◯ A friend / family member ◯ A Silverstein Eye Centers employee ◯ Other: _____

I heard about Silverstein Eye Centers through: (Check all that apply.)

◯ Website and/or internet
◯ Newspaper
◯ Kansas City Mavericks
◯ TV
◯ Yellow Pages
◯ Radio:
☐ 101 The Fox
☐ 106.5 The Wolf
☐ Mix 93.3
☐ 610 Sports Radio
☐ Q104 FM
☐ Hot 103
☐ 98.1 Talk FM / 980 AM
☐ 94.9 FM KCMO Greatest Hits
☐ 810 WHB and ESPN KC

PATIENT INFORMATION- continued

Name _____ **Date of Birth** _____

I would like additional information about the following services:

EYE HEALTH

- ☐ Eye exam
- ☐ LASIK / PRK / Visian ICL
- ☐ Premium lens implants
- ☐ Cataracts
- ☐ Femto Laser-assisted cataract surgery
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Corneal diseases
- ☐ Allergies
- ☐ Dry Eye
- ☐ Eye vitamins

COSMETIC TREATMENTS

- ☐ Blepharoplasty (eye lid surgery) ☐ Latisse
- ☐ Droopy/low-lying lids

RESEARCH – Ophthalmology Clinical Trials

- ☐ Please visit our website for more information about current enrolling studies. www.SilversteinEyeCenters.com

Acknowledgment or Permission given for:

1. Was offered a copy of Silverstein Eye Centers "**Notice of Privacy Practices**".
   ☐ Yes ☐ Refused Copy Patient/Parents/Guardian **Initials**: _____
2. We can contact you by telephone or text and leave a message for the following:
   ☐ Appointment Reminder ☐ Billing inquiry Patient/Parents/Guardian **Initials**: _____
3. I understand there is a separate charge for Refraction (glasses prescription) that insurance does not reimburse.
   Patient/Parents/Guardian **Initials**: _____
4. I have received a copy of Silverstein Eye Centers "**General and Financial Policies**".
   Patient/Parents/Guardian **Initials**: _____
5. ☐ I give my consent to review my records to see if I qualify for a possible research study.
   ☐ I do not give my consent to review my chart to see if I qualify for a possible research study.
   Patient/Parents/Guardian **Initials**: _____
6. I give my consent to Silverstein Eye Centers to disclose my protected health information to the following people:

FULL NAME	DATE OF BIRTH	TELEPHONE NUMBER	RELATIONSHIP TO PATIENT

☐ I choose not to share my information with anyone.

Patient/parent or legal guardian consent to use and disclose health information

With your signature, you are granting Silverstein Eye Centers permission to use and disclose your protected health information for the purpose of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the legal right to review our Notice of Privacy Practices before you sign this consent.

Government policy may require us to change our Notice of Privacy Practices from time to time. If we change our Notice, you may obtain a copy of the revised Notice by requesting a copy at our office. You do have the right to request that Silverstein Eye Centers restrict how we use and disclose your protected health information for the purpose of treatment and payment of health care operations.

You may revoke this consent in writing at any time, at which time Silverstein Eye Centers will cease sharing information but will not retract health information disclosed previously with your consent.

Patient's Signature _____ Date _____

Legal Guardian/ Representative's Signature _____ Relationship to patient _____

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MEDICAL HISTORY

Name _____ **Date of Birth** _____

Health Care Providers

Referring Doctor _____ Phone # ( ) -

Primary Care Doctor _____ Phone # ( ) -

Specialty Care Doctor _____ Phone # ( ) -

Eye Doctor _____ Phone # ( ) -

Preferred Pharmacy & Location _____

Mail Order Pharmacy _____

Reason for today's visit

Chief Complaint / Referred for (Please check the reasons for your visit.)

- ◯ blurry vision
- ◯ blurry spot in vision
- ◯ bump on eyelid(s)
- ◯ burning sensation
- ◯ cataract evaluation
- ◯ cornea disease
- ◯ crossed eyes
- ◯ diabetic eye exam
- ◯ discharge
- ◯ distorted vision
- ◯ dizziness
- ◯ double vision
- ◯ droopy lid(s)
- ◯ dry eye(s)
- ◯ eye lashes turning in
- ◯ new flashes or floaters
- ◯ foreign body sensation
- ◯ glare
- ◯ glasses re-check
- ◯ glaucoma evaluation
- ◯ headaches
- ◯ itchy eyes or eye lids
- ◯ injury
- ◯ sudden loss of vision
- ◯ pain in eye(s)
- ◯ red eye(s)
- ◯ swelling
- ◯ watery eye(s)
- ◯ wishing to be free of glasses or contacts
- ◯ other: _____

Severity ◯ None ◯ Mild ◯ Moderate ◯ Severe

Location ◯ Right Eye ◯ Left Eye ◯ Both Eyes ◯ Other: _____

Timing ◯ None ◯ Intermittently ◯ Constantly ◯ Occasionally ◯ Once

This has been going on for: _____ Hours _____ Days _____ Weeks _____ Months

MEDICAL HISTORY- continued

Name _____ **Date of Birth** _____

Allergies & Reactions ◯ None

◯ Latex _____ ◯ Eye Drops _____

◯ Medication _____

◯ Food _____

◯ Other _____

Vision History ◯ None

◯ Cataracts ◯ Diabetic Retinopathy

◯ Glaucoma ◯ Cornea Disease

◯ Crossed or Lazy Eye ◯ Trauma

◯ Dry Eye ◯ Other: _____

◯ Macular Degeneration _____

Previous Eye Surgeries (Year and Surgeon) ◯ None

◯ Cataract _____

◯ Glaucoma _____

◯ Retina _____

◯ Laser _____

◯ Refractive _____

◯ Injury _____

◯ Other: _____

All Other Past Surgeries (Include Year) ◯ None

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical History (Include Year Diagnosed) ◯ None

◯ Diabetes: Year _____ Type _____

Blood Sugar this am: _____

Last A1C _____ Next A1C _____

◯ Arthritis _____

◯ Cancer (type) _____

◯ High Blood Pressure _____

◯ High Cholesterol _____

◯ Irregular Heartbeat _____

◯ Thyroid Disease _____

Other Health Conditions (Include Year) ◯ None

_____

_____

_____

_____

Prescription Medications, Over-the-Counter Medications, and Vitamins; Including Eye Medications

(Include dosage, strength, and use) ◯ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History

Has anyone in your family (blood relatives) had any of the following? Please note relationship to patient:

P-Parent | S-Sibling | GP-Grandparent | A-Aunt | U-Uncle

Arthritis	P S	GP	A U	Glaucoma	P S	GP	A U	Macular Degeneration	P S	GP	A U
Blindness	P S	GP	A U	Heart Disease	P S	GP	A U	Retinal Disease	P S	GP	A U
Cancer	P S	GP	A U	High Blood Pressure	P S	GP	A U	Stroke	P S	GP	A U
Cataracts	P S	GP	A U	Kidney Disease	P S	GP	A U	Tuberculosis	P S	GP	A U
Diabetes	P S	GP	A U	Lazy Eye	P S	GP	A U	Other / Explain:	P S	GP	A U

_____

_____

Name _____ **Date of Birth** _____

Social History

Smoking
- ◯ Current every day smoker
- ◯ Current some days smoker
- ◯ Former smoker
- ◯ Never smoked

Alcohol
- ◯ Daily
- ◯ Occasionally
- ◯ Seldom
- ◯ Never

Social Drugs
- ◯ Current every day user
- ◯ Current some days user
- ◯ Former user
- ◯ Never used

Review of Systems

Please check if you currently have any of the following:

Vision History ◯ None/ NA
- ☐ Previous Surgery
- ☐ Contact Lens
- ☐ Pain
- ☐ Double Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Dry Eye

Ear, Nose and Throat ◯ None/ NA
- ☐ Hard of Hearing
- ☐ Ringing in the Ears
- ☐ Vertigo / Dizziness

Cardiovascular ◯ None/ NA
- ☐ Chest Pains
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heart Beat
- ☐ Difficulty Lying Flat
- ☐ High Blood Pressure
- ☐ High Cholesterol

Constitutional ◯ None/ NA
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Weight Gain/Loss

Respiratory ◯ None/ NA
- ☐ Cough
- ☐ Congestion ☐ Asthma
- ☐ Wheezing ☐ COPD

Gastrointestinal ◯ None/ NA
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitis

Genito-Urinary ◯ None/ NA
- ☐ Pain / Difficulty
- ☐ Blood in the Urine
- ☐ History of Kidney Stones
- ☐ History of STDs

Psychiatric ◯ None/ NA
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping

Endocrine ◯ None/ NA
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Increased Sweating
- ☐ Increased Thirst
- ☐ Fingernail Changes
- ☐ Diabetes
- ☐ Thyroid

Blood /Lymph Nodes ◯ None/ NA
- ☐ Easy Bruising
- ☐ Gums Bleed Easily
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

Musculoskeletal ◯ None/ NA
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Skin ◯ None/ NA
- ☐ Rashes / Sores
- ☐ Lesions
- ☐ Hives / Eczema

Neurological ◯ None/ NA
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors
- ☐ CVA/Stroke

Immunologic ◯ None/ NA
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

SILVERSTEIN EYE CENTERS P.C.

CANCELLATION POLICIES

In healthcare, good communication between our staff and the patient is important for efficient scheduling, so we may accommodate preventive and emergency care quickly and appropriately for you. We greatly appreciate as much advanced notice as possible for any reason you may need to cancel your appointment. Our staff has significant flexibility and understanding for last minute illness and issues which cause changes in the schedule.

Effective March 17th, 2016, if you do not show up or do not call to cancel your appointment for a **3rd** scheduled appointment, you will be charged $50.00 on your account for that third missed appointment and thereafter on all missed (non-canceled) appointments.

Cancellations made 48-hours in advance will not be charged.

I understand the cancellation policy for Silverstein Eye Centers, P.C.

PATIENT SIGNATURE _____ DATE _____

SILVERSTEIN EYE CENTERS P.C.

GENERAL AND FINANCIAL POLICIES

OFFICE HOURS: Monday through Thursday, 8:00 am to 5:00 pm, Friday 8:00 am to 4:00 pm

OFFICE CONTACT NUMBER: 816.358.3600

TO SCHEDULE AN APPOINTMENT, please have the following information:

- Name of patient
- Name of insurance carrier and name of insured
- Which doctor you wish to see
- Reason for appointment

HOW MUCH TIME TO ALLOW FOR THE APPOINTMENT:
Depending on your symptoms or reasons for your appointment, it may take 2 to 3 hours.

ON YOUR APPOINTMENT DAY:

- Please arrive 30 minutes prior to your appointment to review and update your patient information.
- Have your insurance card(s) with you, along with a photo ID.
- Have co-payment if your insurance requires it.
- Notify us of any insurance or address changes.
- Bring a list of medications you are taking.
- If required by your insurance, bring a referral letter from your primary care physician.

CANCELLATION OR LATE FOR APPOINTMENT:
Call us as soon as possible if you will not be at your scheduled appointment or if you will be late. We make every effort to stay on time with appointments, but emergencies do occur which may affect the schedule. We will keep you informed of any delays.

TELEPHONE ADVICE: Patients are encouraged to call with any medical questions they may have. Our physicians have appointments scheduled continuously throughout the day and only return calls at lunch time and end of day. Response to your questions may come from one of the physicians or from our medical staff team.

LAB RESULTS: Your physician will review your lab results and we will contact you with the results.

PRESCRIPTION REFILL: Patients are requested to allow 24-48 hours during regular business hours when requesting a refill. To insure accuracy of prescription request, we request your pharmacists contact us about your refill. Prescriptions are not refilled after hours or on weekends.

EMERGENCIES: Our main telephone number, 816.358.3600, is answered 24 hours a day. During non-office hours, a physician is available to return your call. If your emergency is life threatening, call 911 and follow the directions given to you.

MOBILITY CHALLENGES: For patients with mobility challenges regarding ambulating or transferring to an exam chair, please inform our staff prior to your visit.

DIVORCE/CHILD CUSTODY: The parent that is accompanying the child is responsible for the payment of the visit and test performed unless a divorce court document is provided noting the person responsible for payment.

YOUR HEALTH INSURANCE COVERAGE: We strongly suggest that you are aware of what your health insurance does and does not cover. Your health care coverage is an agreement between you and your health insurance provider.

REFERRAL OR AUTHORIZATION REQUESTS: Most insurance companies require a referral and authorization from your primary care provider to see a specialist outside of our office. Depending on the insurance, there may be additional processes that are required before certain ordered tests can be done.

NON-COVERED SERVICES: Some services may not be covered under your health insurance or vision care plan. You are responsible for payment for services not covered under your insurance or vision care plan.

INSURANCE AND BILLING: We participate in most insurance plans. If you have questions regarding whether we participate with a specific plan, please ask a member of our staff. Patients are responsible for any fees/co-pays incurred at the time of services.

REFRACTION (EYE GLASSES PRESCRIPTIONS): This procedure is done by either your physician or an ophthalmic technician. This procedure usually is not covered under your insurance. If a prescription is dispensed, payment for the prescription is due at the time of the service.

UNACCOMPANIED MINOR PATIENTS (UNDER THE AGE OF 18): Please contact our office to verify insurance coverage prior to the scheduled appointment. The minor will need the following with them:
1) Written statement giving permission for our staff to treat the patient
2) Referrals or Authorizations required by your insurance
3) Any co-pay or deductibles amounts due at the time of the appointment

RETURNED CHECKS: All returned checks for insufficient funds will be assessed a fee of $30.00.

PATIENT SIGNATURE _____ DATE _____

SILVERSTEIN EYE CENTERS P.C.

Notice of HIPAA Privacy and Security of Health Information Manual

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review the full Notice of HIPAA Privacy and Security of Health Information Manual available at the clinic. If you have any questions about this notice, please contact the Privacy Officer at (816) 358-3600.

WHO WILL FOLLOW THIS NOTICE:

- Silverstein Eye Centers, PC

This notice describes our privacy practices. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment, or healthcare operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

Uses and Disclosures of Health Information about you: The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Silverstein Eye Centers, PC. For example, information on the services you received may be used to support budgeting, financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Workers' Compensation Claims. Your health information may be used to seek payment from employers Workers' Compensation Division.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the

authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising. Unless you request us not to, we will use your name and address to support our fundraising efforts.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

Individual Rights

You have certain rights under the federal privacy standards that we maintain about you. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Information on how to exercise these rights can be obtained from the Privacy Officer at (816) 358-3600.

Silverstein Eye Centers, PC. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations.

Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

SILVERSTEIN EYE CENTERS, PC.

4240 BLUE RIDGE BOULEVARD, SUITE 1000

KANSAS CITY, MO 64133

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer

(816) 358-3600

Effective Date

This notice is effective on or after:
September 3, 2013.