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PEDIATRIC INFORMATION SHEET

DATE _____ SOCIAL SECURITY NUMBER:_____

Patient Information

NAME _____ EMAIL ADDRESS _____
(FIRST) (M) (LAST)

STREET ADDRESS _____ CITY_____

STATE _____ ZIP _____ COUNTY _____ SEX: M / F DOB _____

AGE _____ HOME PHONE _____ OTHER PHONE _____ CELL # _____

RACE _____ ETHNICITY ☐Hispanic ☐Non-Hispanic ☐Prefer Not To Answer
(CHECK ONE PLEASE)

PREFERRED LANGUAGE:_____

Mother's Information

NAME _____ MAIDEN NAME _____ DOB _____

SS # _____ EMPLOYMENT _____ WK# _____

Father's Information

NAME _____ DOB _____

SS # _____ EMPLOYMENT _____ WK# _____

Medical Insurance Information: PROVIDE A COPY OF EACH INSURANCE CARD

Primary Policy Holder Name _____

PRIMARY INS. _____ SECONDARY INS. / MEDICAID _____

PERSON TO NOTIFY IN CASE OF EMERGENCY, OTHER THAN PATIENT

NAME _____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ PH _____

INFORMATION ON FORM IS PROTECTED HEALTH INFORMATION (PHI) AND IS TO BE TREATED AS CONFIDENTIAL UNDER HIPAA RULES - PRIVACY & SECURITY OF THIS INFORMATION IS ESSENTIAL, ALL SERVICES ARE CHARGED DIRECT'LY TO THE PATIENT, AND THE PATIENT OR THE PATLENT'S REPRESENTATIVE REMAINS PERSONALLY RESPONSIBLE FOR PAYMENT, AS A COURTESY, WE WILL FILE INSURANCE CLAIMS FOR OUR PATIENTS; HOWEVER, **THE PATIENT'S PORTION OF THE FEE AND/OR CO-PAYS IS - DUE AT THE TIME OF SERVICE.** **ACKNOWLEDGEMENT;** I CONSENT TO USE OF PHI FOR PURPOSES OF TREATMENT, PAYMENT ***AND*** OPERATIONS ***AND,*** AUTHORIZE THE ENTITY TO USE THE PHI AS NEEDED. I AUTHORIZE THAT PAYMENT OF BENEFITS, INCLUDING MEDICARE BENEFITS, BE MADE ON MY BEHALF DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY **RESPONSIBLE** FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. IN MEDICARE ASSIGNED CASE, THE PHYSICIAN AGREES TO ACCEPT THE CHARGES DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE AND THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICE.

_____ _____ _____
PATIENT SIGNATURE REPRESENTATIVE SIGNATURE DATE

JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

This patient history form and the information you provide is very important to your healthcare and treatment. Please take the time to fully and accurately complete this patient history questionnaire.

Thank you,
Dr. Jennifer Madon, M.D.

THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY BELIEF.

_____ _____

Patient/Parent/Guardian Signature **Date**

JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

MEDICAL HISTORY FORM

GENERAL Have you had any of the following in the past six months, or suffer from these chronically? (Please place a check mark to those that apply).

ENDOCRINE
____ Swelling under arms or neck
____ Weakness and lethargy
____ Always hungry
____ Increased thirst
____ Increased urination
____ Tend to be too hot
____ Tend to be too cold
____ Fever and chills
____ Night sweats
____ Problems going to sleep
____ Problems waking up after falling asleep
____ Recent weight gain
____ Recent weight loss
____ Diabetes

PSYCHIATRIC
____ Depression
____ Anxiety
____ Cry often
____ Feel sad
____ Loss of self-interest
____ Loss of interest in eating
____ Hear voices
____ Nervous breakdown

EARS, NOSE & THROAT
____ Wear glasses or contacts
____ Eye discharge
____ Blurry vision
____ Recent changes in vision
____ Decreased hearing
____ Earache or drainage
____ Ringing in ears
____ Allergies
____ Sinus trouble
____ Nose bleeds
____ Sore throat
____ Sores on the tongue
____ Goiter/thyroid problems
____ Neck pain or lumps
____ Any change in voice
____ Dental problems
____ Sores in the mouth

INFECTIONS
____ Rheumatic fever
____ Measles
____ Mumps
____ Chicken pox
____ Hepatitis B
____ Hepatitis C
____ Polio
____ AIDS (or positive test)
____ Syphilis (or other sexually transmitted diseases)

PULMONARY
____ Chronic snoring
____ Persistent cough
____ Coughing up blood
____ Coughing up secretions each morning
____ Stopped breathing while asleep
____ COPD, emphysema or chronic bronchitis
____ Asthma

HEMATOLOGY
____ Anemia/low blood count
____ Blood disease
____ Sickle cell disease
____ Radiation exposure
____ Bleeding/bruising easily
____ Skin cancers
____ Other cancers (Please indicate on back of form)

MUSCULOSKELETAL
____ Gout
____ Pain in fingers or hands after exposure to cold
____ Muscle or joint pain
____ Leg camps after walking
____ Leg cramps at night
____ Arthritis

NEUROLOGY
____ Frequent headaches
____ Migraines
____ Seizures
____ Stroke or paralysis
____ Memory problems
____ Meningitis
____ Nerve damage to feet or hands
____ Trembling spells

CARDIOVASCULAR
____ Chest pain
____ Heart palpitations
____ Dizzy upon standing
____ Swelling in feet/hands
____ High cholesterol
____ Fainting spells
____ Shortness of breath with exercise
____ Having to sit up intermittently at night
____ Prior heart surgery

GASTROINTESTINAL
____ Heartburn
____ Belching
____ Loss of appetite
____ Nausea or vomiting
____ Liver disease
____ Jaundice or hepatitis
____ Difficulty swallowing
____ Stomach pain
____ Recent change in bowel habits
____ Diarrhea
____ Constipation
____ Bloody stools
____ Rectal pain
____ Hemorrhoids
____ Rectal fissure
____ Parasites or worms
____ Pancreatitis

GENITOURINARY
____ Frequent urination
____ Burning on urination
____ Difficulty starting urination
____ Dribbling of urine with cough
____ Kidney stones
____ Kidney disease
____ Sexual difficulty

MEN ONLY
____ Weak urine stream
____ Prostate problems
____ Lump on testicle(s)
____ Problem with sexual intercourse
____ Burning or discharge

WOMEN ONLY
____ Cesarean section
____ Hysterectomy
____ Toxemia during pregnancy
____ Diabetes during pregnancy
____ Lumps in breast
____ Date/last pap smear
____ Pregnancies
____ No. of miscarriages
____ Date of last period
____ Menstrual problems
____ Excessive menstrual bleeding

ALLERGIES (List)

_____
_____
_____

SURGERIES (List)

_____
_____
_____

Family History: Mother: _____

Father: _____

MEDICATION LIST: _____

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Authorization for Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), your protected health information is confidential unless written authorization is given.

Therefore, I, _____(print name) hereby authorize Brian C. Griner, MD, LLC to give my protected health information to the following persons:

NOTE: IF YOU DO NOT LIST YOUR SPOUSE/SIGNIFICANT OTHER ON THIS LIST, WE WILL NOT BE ABLE TO DISCUSS YOUR CARE WITH HIM/HER.

Name	**Relationship**
_____	_____
_____	_____
_____	_____

OR

I request that you DO NOT disclose my protected health information to anyone other than me. _____
Initial

___ **Do** / ___ **Do Not** leave messages on my answering machine or voicemail
___ **Do** / ___ **Do Not** call me at home
If not, please provide an alternate telephone contact number: _____
___ **Do** / ___ **Do Not** call my cell phone Cell (_____) _____ - _____
___ **Do** / ___ **Do Not** send me text messages to notify me of appointment reminders
___ **Do** / ___ **Do Not** call me at work
___ **Do** / ___ **Do Not** mail appointment reminders or other correspondence to my home. If not, please provide alternate mailing address:

_____
_____

This remains in effect until I give written notification to discontinue.

I also understand that, in an urgent medical situation, Brian C. Griner MD, LLC may need to contact me by any means available. _____ (Initial)

_____ _____
Signature of Patient Date

Parent/Guardian of minors under age 18 has access to medical records, with the exception of any State Law protecting the privacy of information of minors.

JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

For all patients:

Please make sure that all parties including your contact person for emergency situations are listed on the attached power of attorney form.
Without this authorization we cannot authorize any treatment for pediatric patients for a child brought by someone else other than parents and/or release any medical information including prescription pick up and medical records to anyone other than the parties on this form.

Thanks for your cooperation.

Jennifer Madon, M.D.

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON I DESIGNATE (MY AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR MY DEPENDENT CHILD, INCLUDING POWER TO CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT.

DESIGNATION OF HEALTH CARE AGENT:

I, _____, _____, HEREBY APPOINT:
(PRINTED NAME) (SOCIAL SECURITY NUMBER)

AGENT NAME: _____

ADDRESS: _____

PHONE: _____

RELATIONSHIP: _____

AS MY ATTORNEY-IN-FACT (MY AGENT) TO ACT FOR ME AND IN MY NAME IN ANY WAY I COULD ACT IN PERSON TO MAKE ANY AND ALL DECISIONS CONCERNING THE PERSONAL CARE, MEDICAL TREATMENT, AND HEALTH CARE REQUIRED FOR MY DEPENDENT CHILD:

NAME OF CHILD: _____

SSN OF CHILD: _____

MY AGENT SHALL HAVE THE SAME ACCESS TO MY CHILD'S MEDICAL RECORDS THAT I HAVE, INCLUDING THE RIGHT TO DISCLOSE THE CONTENTS TO OTHERS.
DURATION: THIS POWER OF ATTORNEY SHALL REMAIN VALID UNTIL _____
(ENTER TERMINATION DATE OR "INDEFINITE")

HOLD HARMLESS PROVISION: ALL PERSONS OR ENTITIES WHO IN GOOD FAITH ENDEAVOR TO CARRY OUT THE TERMS AND PROVISIONS OF THIS DOCUMENT SHALL NOT BE LIABLE TO ME OR MY DEPENDENT CHILD OR RESPONSIBLE FOR ANY DAMAGES OR CLAIMS ARISING BECAUSE OF THEIR ACTION OR INACTION BASED ON THIS DOCUMENT.
STATEMENT OF INTENTIONS: IT IS MY INTENT THAT THIS DOCUMENT BE LEGALLY BINDING AND EFFECTIVE. IF THE LAW DOES NOT RECOGNIZE THIS DOCUMENT AS LEGALLY BINDING AND EFFECTIVE, IT IS MY INTENT THAT THIS DOCUMENT BE TAKEN AS A FORMAL STATEMENT OF MY DESIRE CONCERNING THE METHOD BY WHICH ANY HEALTH CARE DECISIONS SHOULD BE MADE ON MY BEHALF. I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS DECLARATION.

SIGNATURE OF PERSON DESIGNATING AGENT: _____

WITNESS SIGNATURE: _____

NOTARY SIGNATURE: _____

SIGNED ON _____ DAY OF _____ YEAR _____

JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

PATIENT POLICIES AND PROCEDURES

We are delighted you chose our Practice for your medical care needs. We will do our best to ensure you have a positive experience from check-in to check-out each time you visit the office(s). We will also strive for excellence in our customer service to you because you are the reason we are here; to serve you!

As a new patient of this Practice, please take a moment to familiarize yourself to our Policies and Procedures. There are several operating policies we must share with you to ensure our office is efficient, and that all patients receive the best care possible.

Main Office (117 W. Northside Drive):
The main office primarily handles Dr. Griner's well visits for pediatric and adult patients, scheduled re-visits and check-ups, and procedures (immunizations, lab work, etc.). Appointments required. **Office hours M-Th 8:15a-12:00p & 1:15p-5:00p, F 8:15a-12:00p**

Dr. Madon's Office (101-G W. Northside Drive):
Dr. Madon's office is located between the Main office and the Winnersville Walk-In Clinic and serves her pediatric patients as well as our allergy lab through United Allergy Labs. Appointments required. **Office hours M-Th 8:15a-12:00p & 1:15p-5:00p, F 8:15a-12:00p**

Winnersville Walk-In Clinic (101-F W. Northside Drive):
Exclusive to Dr. Griner and Dr. Madon patients only, patients can be seen on a walk-in basis. Under the supervision of Dr. Griner, the Walk-In clinic is staffed by Nurse Practitioners and Physician Assistants. If you or your child is sick, you can bring them to the clinic. No appointment needed. **Office hours M-Th 8:15a-11:00a & 1:15p-4:00p, F 8:15a-11:00a**

General Operating Policies

Appointments: We will do our best to provide you with an appointment that accommodates your schedule, however, please understand our schedule remains full and there will be times when we cannot accommodate a particular time slot.

Prior to your upcoming appointments, we utilize a call reminder system to provide you with a courtesy call four (4) days in advance of your upcoming appointment. Please make sure you have provided our office with a working phone number to communicate this and other important medical information to you. Please inform our office as soon as possible if you have a conflict in making/keeping your appointment, so that we may add any last minute reschedules in your slot.

Contact Information: We rely on our patients to keep us up to date whenever his/her contact information changes, such as an address, phone number, or emergency contact. Please notify us at your next visit or before if you experience a change to your contact information.

Financial Policy: We have developed a detailed policy (separate form) concerning your financial obligations relating to services rendered at our Practice. Please familiarize yourself with these obligations and we welcome your questions if you do not understand or would like clarification about a particular policy.

JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
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Missed Appointments: As mentioned previously, our schedule remains full, sometimes booked out as much as six (6) months in advance. It is the patient's responsibility to contact our office to reschedule/cancel an appointment. If you fail to notify our office to cancel/reschedule your appointment **at least 24-hours in advance**, your account will be charged a **$25.00** "no-show" fee. Please note the fee will not be billed to your insurance company. In addition, your chart will be flagged and you will receive a notice that you have missed an appointment. Accounts that accumulate three (3) or more missed appointment fees may be dismissed from the practice.

Medical Records/Paperwork Requests: It is our policy not to release any medical records, including immunization records, without first having the patient complete an Authorization to Release Medical Records. Anyone of our Check In/Out staff members can assist you with this request. Please note it may take 24-48 hours (1 week for Leave/FMLA paperwork) to complete your request. In addition, it is our policy to charge a small administrative fee for such paperwork at the time of request. Please note the following fee schedule:

Request Type	Fee Charged
Patient Records (which exceeds 5 pages)	$15.00
Leave of Absence (FMLA) certifications, Short/Long Term Claim forms, DME/Medical Necessity forms, etc.	$10.00
Inter-office requests from referral/requesting physicians	No Charge

Patient Rights and Responsibilities: At your first visit, you will be provided with our Practice's HIPAA policy as it relates to the handling, distribution, and storage of your Protected Health Information, more commonly referred to "PHI". You will also be provided with a document to complete which tells our staff who may receive your "PHI" and how you would like our office to communicate important medical information and appointment reminders to you and your designated parties or "Power of Attorney's". You have the ability to change/revoke your authorization at any time by completing another authorization form.

If you feel that your protected health information "PHI" has been inappropriately used, accessed, or released, you may file a complaint with the Privacy Officer, Brett Johnson. Please contact our office at (229) 242-6061 and ask to speak with him. We take your concerns seriously and our staff understand their obligations to protect the confidentiality of your "PHI."

Acknowledgment:
By signing below, I certify that I have read, understand, and agree to abide by the policies set forth herein. I also agree that I have had all questions answered to my satisfaction.

_____
Patient Name

_____ _____
Patient /Responsible Party Signature Date

JENNIFER MADON M.D.
101G W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

Patient No-Show Policy

Brian C. Griner, MD, LLC schedules many patients every day. It is important to honor scheduled appointments or cancel them with enough notice so that another patient can be scheduled in the appointment time. Effective **April 8, 2013**, our Practice has implemented a new no-show policy to assist in the scheduling of patients and manage missed appointments by charging a no-show fee.

Appointments not cancelled or rescheduled **within 24 hours** of the scheduled appointment time will be charged a **$25.00** no-show fee. The no-show fee applies equally to all appointment types and is not covered by insurance; therefore the fee is the patient's responsibility and must be paid prior to your next office visit.

Automated call reminders are provided as a courtesy, **four (4) days** prior to a scheduled appointment. Patients are responsible for notifying the office in advance, if they are not able to keep an appointment.

Patients who miss **three (3)** or more scheduled appointments or who chronically reschedule appointments in a **twelve (12) month** period may be dismissed from the Practice.

Acknowledgement of No-Show Policy

By signing below, I acknowledge receipt of this notice and agree to abide by the terms of the policy.

_____ _____

Patient Name Date

_____ _____

Patient /Responsible Party Signature Responsible Party Relationship to Patient

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HIPAA 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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO), and for other purposes that are required by law. It also describes your rights and our obligations regarding the use and disclosure of that information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering diagnostic tests. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. We may also tell your health plan about a treatment you are going to receive to determine whether your plan will cover the treatment.

Healthcare Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may disclose your health information to medical students that may be training in our office(s). We may contact you as a reminder that you or your child(ren) have an appointment for treatment or medical care at the office.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

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To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose your health information when required to do so by federal, state, or local law.

Disaster Relief Efforts: We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release information about you.

Worker's Compensation: We may release health information about you for Worker's Compensation or similar programs. The programs provide benefits for work-related injuries or illnesses.

Public Health Disclosures: We may disclose health information about you for public health purposes. These purposes generally include the following:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- reporting to the employer findings concerning a work-related illness or injury or workplace-related medical surveillance;
- notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

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- to identify or locate a suspect, fugitive, material witness, or missing person;
- about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death suspected to be the result of criminal conduct;
- about criminal conduct at Brian C. Griner, MD, LLC; and
- in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without specific, written *authorization*. We must obtain your *authorization* separate from any other acknowledgement we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Rights to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated privacy officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, and other associated supplies.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to our designated privacy officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

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Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction. If we do agree, we will comply with your request unless the information is needed to provide proper medical treatment.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate all reasonable requests.

Right to a Paper copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice in our office with its effective date. You are entitled to a copy of the Notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy officer at **(229) 242-6061**. You will not be penalized for filing a complaint.

If you feel your complaint with our office was not handled appropriately, you may contact the Department of Health and Human Services at:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

THIS NOTICE WAS ORIGINALLY PUBLISHED AND BECAME EFFECTIVE APRIL 14, 2003, AND WAS REVISED EFFECTIVE FEBRUARY 19, 2013.