GRINER MEDICAL GROUP
3301 N Oak St. Ext.
Valdosta, GA. 31605

PEDIATRIC INFORMATION SHEET

DATE______________________________ SOCIAL SECURITY NUMBER:______________________________

Patient Information

NAME____ EMAIL ADDRESS__________________________________

STREET ADDRESS ____ CITY__________________

STATE________ZIP___________COUNTY________________________SEX: M/F DOB_______________________

AGE__________HOME PHONE_________________ALTERNATE PHONE________________________CELL #________

RACE______________________________ ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC ☐ PREFER NOT TO ANSWER
(CHECK ONE PLEASE)

PREFERRED LANGUAGE_____________________________

MOTHER INFORMATION

NAME__________________________ MAIDEN NAME _______________DOB________________SS# _______________

EMPLOYER_________________________ OCCUPATION_______________________ WORK # ____________________

EMPLOYER ADDRESS/CITY/ZIP ____

FATHER INFORMATION

NAME____________________________________DOB________________________SS# _______________________

EMPLOYER_________________________ OCCUPATION_______________________ WORK # ____________________

EMPLOYER ADDRESS/CITY/ZIP ____

Medical Insurance Information: PROVIDE A COPY OF EACH CARD

Primary Policy Holder Name ____

PRIMARY INS. _____________________________ Secondary INS. / MEDICAID _________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN PARENT

NAME____________________________________RELATIONSHIP TO PATIENT_________________ PHONE______________

ADDRESS __________________________CITY_________________ STATE________ZIP___________

INFORMATION ON THIS 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 DIRECTLY TO THE PATIENT, AND THE PATIENT OR THE PATIENT'S RESPRESENTATIVE 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 COPAY 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 A MEDICARE ASSIGNED CASE, THE PHYSICIAN AGREES TO ACCEPT THE CHARGES DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE AND THE PATIENT IS RESONSIBLE FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICE.

_____________________________ _____________________________ _________________
PATIENT SIGNATURE REPRESENTATIVE SIGNATURE DATE

GRINER MEDICAL GROUP
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In order to best protect our patients and due to the risk of exposure, Griner Medical Group **will no longer accept new unvaccinated patients or patients who are planning not to vaccinate. This is childhood vaccines only. We do not require COVID vaccines.**

We are in agreement with all the board-certified pediatricians in our community, that vaccinating children is in the best interest of their health.

Acknowledgement:

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 Signature Date

____________________________________ _____________________

Representative Signature Date

GRINER MEDICAL GROUP
3301 N Oak St. Ext.
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Vaccine Policy

Brian C. Griner, MD, LLC schedules many patients every day. We do our best to accommodate patients by giving them timely appointments appropriate to their vaccine requirements.

Our office follows the schedule for children's vaccines that have been set by the CDC, AMERICAN PEDIATRIC ASSOC, & THE GEORGIA DEPT OF HEALTH. I have adjusted the needed vaccines from their schedule to one of my own, which means your child should not get more than 3 injections at any one visit.

This works well with most however; we are getting an increasing number of parents who want to "SPLIT" the doses into 2-3 visits.
This is indeed a parent's choice, but the State of Ga. VFC department has increased their audits for childcare and school facilities, to ensure that children are receiving the vaccines they need in a timely manner; therefore, many parents are having a problem keeping their vaccination records valid. This is not only a burden on the parent by having to take the child out of the facility, but also a burden on my staff trying to accommodate the patient flow.

We have no control over the daycare facility and we have found it necessary to notify each parent that if they <u>split vaccines</u>, <u>reschedule</u>, or <u>no show an appointment</u> they are taking a risk of their child's record becoming invalid at some point between birth to 2 years of age.

Acknowledgement of vaccine schedule policy

By signing below, I acknowledge the importance of making sure my child keeps appointments scheduled for their vaccines.

______________________________	______________________________
Patient Name	Date
______________________________	______________________________
Responsible Party Signature	Responsible Party Relationship to patient

GRINER MEDICAL GROUP
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Laboratory Notice

Griner Medical Group Parents/Patients:

Griner Medical Group currently uses QUEST LAB for our laboratory services. Please notify our staff before any blood work is drawn if you need to use a different laboratory facility. We will not be held accountable for any insurances declining to pay for services done in our office.

We have no control over who your insurance company covers. It is your responsibility to notify our office if you cannot use Quest Labs for blood work. We will gladly give you a written order to get your labs drawn elsewhere.

We have found it necessary to notify our patients that if you need to get labs done at a different facility, we need to be notified immediately. This will lessen any confusion with your insurance company and guarantee that your bills will be paid.

Acknowledgement of laboratory notice

By signing below, I acknowledge the importance of making sure that I notify Griner Medical Group if I need to get labs drawn at a different facility.

____________________________ ____________________________
Patient Name Date

____________________________ ____________________________
Responsible Party Signature Responsible Party Relationship to patient

GRINER MEDICAL GROUP
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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. Brian Griner, M.D.

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

______________________________ ________________

Patient/Parent/Guardian Signature **Date**

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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 tongue
___Goiter/thyroid problems
___Neck pain or lumps
___Any change in voice
___ Dental problems
___Sores in 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 coughs
________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 finger or hands after exposure to cold
________Muscle or joint pain
________ Leg cramps after walking
________leg cramps at night
________arthritis

FAMILY HISTORY:
MOTHER:______________________
FATHER:______________________

Neurology
________frequent headaches
________migraines
________seizures
________stroke or analysis
________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)
____
____
____

MEDICATIONS (LIST)
____
____

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For all patients, parents, and legal guardians:

Please make sure that all parties including your contact person for emergency situations are listed on the Power of Attorney document (POA).

Without authorization from biological parents or legal guardians, **WE CANNOT** authorize any treatment for pediatric patients for a child brought by someone else other than parents/legal guardian or release any medical information including prescription pick-up and medical records too anyone other than the parties on the POA form.

We can no longer speak with parent or legal guardians over the phone to verify information. Documents have to be in place **prior** to visit.

Thank you for your cooperation.

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Authorization for Disclosure of Protected Health Information and Power of Attorney for Health Care

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 and its staff to give **my** or **my child's**, ____________________________DOB________ (print child's name) protected health information and/or **to act on my behalf in my absence to** the following persons **(must be at least 18 years old):**

NOTE: IF YOU DO NOT LIST ANY NAMES BELOW, WE WILL NOT BE ABLE TO DISCUSS YOUR OR YOUR CHILD'S CARE WITH ANYONE OTHER THAN YOU. (IN SITUATIONS INVOLVING A MINOR CHILD, ONLY BIOLOGICAL MOM AND DAD OR APPOINTED GUARDIAN OF CHILD WITH APPROPRIATE PAPERWORK) WILL BE ABLE TO RECEIVE INFORMATION ON OR ACT ON BEHALF OF CHILD. APPOINTMENTS WILL BE RECHEDULED IF A CHILD PRESENTS TO A VISIT WITHOUT APPORVED GUARDIAN/POWER OF ATTORNEY.

NAME	RELATIONSHIP TO PATIENT	PHONE #
____________________________	_____________________	_____________________
____________________________	_____________________	_____________________
____________________________	_____________________	_____________________

****OFFICE STAFF: A PICTURE SHOULD BE CAPTURED OF EACH NAME LISTED ABOVE AND UPLOADED TO THE PATIENT'S CHART FOR VERIFICATION PURPOSES AT THE TIME OF CHECK-IN. ****

-OR-

I request that you **DO NOT** disclose my (or my child's) protected health information to anyone other than me. __(Initial)

This directive shall remain in effect as of the date of my signature, until I give written notification to discontinue. I also hold harmless all persons or entities who act in good faith and in accordance with HIPAA to carry out the terms and provisions of this document, and also release responsibility for any damages or claims arising because of their action or inaction based on this document. I also understand that, in an urgent medical situation, Griner Medical Group may need to contact me by any means available. ____(Initial)

____   _____________________
Signature of Patient   Date

____   _____________________
Parent/Legal Guardian Signature **(if patient is a minor)**   Date

____   _____________________
Notary Signature   Date

____   _____________________
Witness Signature **(Office Staff Only)**   Date

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

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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 the 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 out office is efficient, and that all patients receive the best care possible.

Griner Medical Group:
The main office primarily handles Dr. Griner's well visits for pediatric and adult patients, scheduled re-visits and check-ups, and procedures (immunization, lab work, etc).
Appointments required. **Office hours M-Th 8:15am-12:00pm & 1:15pm-5:00pm, Friday 8:15am-12pm**

Griner Medical Group Walk-in:
Patients can be seen on a walk-in basis. Under the supervision of Dr. Griner, the Walk-in hours is staffed by Nurse Practitioners. If you are sick, you can come in at clinic hours. **Office hours M-Th 8:15am-11:30am & 1:15pm-4:30pm, Friday 8:15am-11:15pm.**

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.

[over]

GRINER MEDICAL GROUP
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Financial: 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.

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 appointments fees may be dismissed from the practice.

Medical Records/Paperwork Request: 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 (10-21 days 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:

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 as "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, Cathy Harrison. Please contact our office at (229) 242-6061 and ask to speak with her. We take concerns seriously and our staff understands their obligations to protect the confidentiality of your "PHI".

Request Type	Fee Charged	Additional Fees
Patient Records (which exceeds 5 pages)	$15.00	
Short/Long Term Claims forms, Insurance forms, DME/Medical Necessity forms, Biomedical plasma forms etc.	$10.00	$15- records less than 20 pages $25 - records 21-50 pages $35- records 51-100pages $50- records over 100 pages
Inter-office request from referral/requesting physicians	No charge	No charge
Leave of Absence (**FMLA**) certifications	$25.00	

****** THESE PRICES ARE SUBJECT TO CHANGE******

Acknowledgement: 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

GRINER MEDICAL GROUP

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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 charges 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 appointment.

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

Acknowledge 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

GRINER MEDICAL GROUP

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Patient Financial Policy

Thank you for choosing Brian C. Griner MD, LLC as your primary care provider. We are committed to providing you with quality and affordable health care. Due to the amount of outstanding accounts, we find it necessary to inform you of our financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request and will also be kept on file in our practice.

1. **Insurance.** We participate in most insurance plans, including Medicare. If we are not a participating provider on your plan, payment in full is expected at each visit. If we are a participating provider on your plan, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is **your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles. All** co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company**. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.**
   Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive (including lab work) may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for all of the charges incurred and be temporarily designated as a self-pay patient until verification of coverage is received.

5. **Self-Pay.** If you are not covered under an insurance plan, you will be considered self-pay. In order to be seen, Self-Pay patients are required to pay a portion of the visit (usually $50.00) at the time of service. This payment will be applied to your final bill for the visit. Charges are determined based on standard medical coding and billing practices and are dependent on a variety of factors; which include the type and nature of the visit, and other services or 2 procedures performed during the visit. Therefore, an additional bill may follow depending on the services rendered. Also, patients who require lab work and durable medical equipment may receive additional charges.

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6. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpayment.** Our billing company supplies you with a statement each month concerning any outstanding balances. It is your responsibility to pay any outstanding balance showing due by the due date listed on the invoice. If your account becomes over 90 days past due, you will be required to remit a minimum payment of $50.00 at your next office visit in addition to your normal co-payment/co-insurance before services/treatment will be rendered. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If your account is turned over to a collection agency, you will be responsible for any fees assessed to collect your past due amount(s) in addition to the outstanding balance.

9. **Forms of Payment.** Our office accepts the following forms of payment:
   - Cash
   - Check
   - Credit/Debit Cards – Visa, MasterCard, Amex, and Discover

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____
Patient Name

____ __________________
Signature of patient or responsible party Date

GRINER MEDICAL GROUP
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HIPAA AND OUR PATIENTS

- The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in April 2001. This rule essentially controls the use and disclosure of what is known as Protected Health Information. Implementation of and compliance with this rule is not optional for our practice. We are required to give you the attached information.

- Please read and familiarize yourself with the attached material. It is your copy so feel free to take it with you.

- Sign this page and turn it in to the medical assistant taking care of you. It will be a permanent part of your medical record.

FROM:____

PATIENT'S NAME

TO: BRIAN C. GRINER, M.D., LLC

RE: HIPAA NOTICE OF PRIVACY PRACTICES

As a patient of the above physician,
I acknowledge receipt of the HIPAA Notice of Privacy Practices.

____

PATIENT SIGNATURE DATE

OR

____

PATIENT'S REPRESENTATIVE DATE
(PARENT/GUARDIAN)

GRINER MEDICAL GROUP
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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) has 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.

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

- 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.

GRINER MEDICAL GROUP
3301 N Oak St. Ext.
Valdosta, GA. 31605

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.

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.