MEADOWS MEDICAL GROUP
REGISTRATION FORM

(Please Print)

Today's date	

PATIENT DEMOGRAPHIC INFORMATION

Last Name		Employer Name	
First Name		Employer Address	
Middle Name		Employer City	
Birthdate _____ / _____ / _____ MM / DD / YYYY		Employer State	ZIP Code
Sex ☐ Male ☐ Female ☐ Other		Employer Phone	
Social Security Number		Occupation	Employment Status ☐ FT ☐ PT ☐ Unemployed
Address		Language	
City	Zip Code	Marital Status	
State		Race	
Email Address or N/A ☐		Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	
Home Phone		Cell Phone	
Work Phone		Primary Care Provider	

PATIENT DEMOGRAPHIC INFORMATION (FOR MINORS ONLY)

MOTHER'S INFORMATION	FATHER'S INFORMATION
Name	Name
DOB Social Security Number	DOB Social Security Number
Address	Address
City, State, Zip	City, State, Zip
Home Phone Number	Home Phone Number
Cell Phone Number	Cell Phone Number
Employer Name	Employer Name
Work Phone Number	Work Phone Number

INSURANCE INFORMATION

Primary Insurance		
Name of Insurance Holder (Last, First, Middle)		
Relation to Patient		
Birthdate	Sex ☐ Male ☐ Female	
Address		
City	State	Zip
Insurance Holder Phone Number	Phone Type ☐ Home ☐ Cell ☐ Work	
Policy Number	Group Name	
Group Number		

EMERGENCY CONTACT INFORMATION

Name (Last, First, Middle)		
Relation to Patient	Phone	Type ☐ Home ☐ Cell ☐ Work
Address		
City	State	Zip

GUARANTOR INFORMATION
SKIP IF SAME AS PATIENT

Name (Last, First, Middle)		
Relation to Patient	Social Security Number	
Address Line 1		
City	State	Zip
Home Phone	Cell Phone	
Employer Name	Employer Address	
Employer City	Employer State	Employer Zip Code
Employer Phone	Employer Fax	
Employment Status ☐ FT ☐ PT ☐ Unemployed		

COMMUNICATION PREFERENCES REGARDING:						
	Appointment		Clinical		Financial	
Method **(Check for All: ☐)**	May Call	May Leave Messages	May Call	May Leave Messages	May Call	May Leave Messages
Cell Phone	☐	☐	☐	☐	☐	☐
Home Phone	☐	☐	☐	☐	☐	☐
Work Phone	☐	☐	☐	☐	☐	☐

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTIFICATION FORM

Signature below is acknowledgement that have been given and had the opportunity to read our **Notice of Privacy Practices**. Should you wish to read the Notice at any other time, please request upon the arrival of your office visit. Any questions concerning our policy should be directed to our staff for clarification. It is our policy to provide this Notice at your first visit, and you may obtain another copy at any subsequent visit. This acknowledgment and authorization remains in effect until we are notified, in writing, by you of any changes.

Please list all additional authorized persons with whom we may discuss any of your medical information (including scheduled appointments):

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

Patient Name	Patient's DOB
Signature	Today's Date

NEW PATIENT REGISTRATION – ACKNOWLEDGEMENT AND DISCLOSURES
STANDARD FORM FOR ALL ENTITIES ASSOCIATED WITH SOUTHEAST REGIONAL PRIMARY CARE CORPORATION AND/OR MEADOWS REGIONAL MEDICAL CENTER, INC. OF WHICH THIS CENTER IS ASSOCIATED

PHYSICIAN PRACTICES POLICY AND RELEASE OF INFORMATION
The following is a statement of our Financial Policy for services provided within our office and does not apply to any testing or diagnostic procedure performed outside of the physician practice. We require you to read and sign this document prior to treatment by this facility.

PATIENT RESPONSIBILITY
All professional services rendered are charged to the patient and are due at the time of service. As a courtesy, this practice will file your claim with your insurance carrier; however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. **Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service**.

Initial: _____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is the patient's responsibility to understand their insurance coverage.

Initial: _____

When you receive a statement, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you must contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery.

Initial: _____

AUTHORIZATION FOR TREATMENT AND TO RELEASE INFORMATION
The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for our office to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator and/or other health benefit payor or representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization serves as permission to obtain a copy of your complete medical record for or from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, by communicating to the practice either in writing or verbally, followed by a written withdrawal.

Initial: _____

I understand that I am financially responsible for any balance not covered by the insurance carrier.

ASSIGNMENT OF BENEFITS
I hereby assign and authorize my insurance benefits or claims to be paid directly to this office.

_____
PATIENT NAME (PLEASE PRINT)

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

HISTORY FORM

NAME: _____ **DATE OF BIRTH:**_____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Blood/Lymphatic
___ Unexplained Lumps
___ Easy Bruising/Bleeding

Ears/Nose/Throat/Mouth
___ Difficulty Hearing/Ringing in Ears
___ Hay Fever/Allergies/Congestion
___ Trouble Swallowing

Genitourinary
___ Painful/Bloody Urination
___ Leaking Urine
___ Nighttime Urination
___ Elevated PSA

Constitutional
___ Recent Fever/Sweats
___ Unexplained Fatigue/Weakness
___ Unexplained Weight Loss/Gain

Gastrointestinal
___ Heartburn/Reflux
___ Blood or Change in Bowel Movement
___ Nausea/Vomiting/Diarrhea
___ Pain in Abdomen
___ Hemorrhoids
___ Loss of Bowel Control

Breast
___Breast Lump(s)
___ Nipple Discharge

Endo
___ Cold/Heat Intolerance
___ Increase Thirst/Appetite

Musculoskeletal
___ Muscle/Joint Pain
___ Recent Back Pain

Skin
___ Rash
___ New or Change in Mole

Cardiovascular
___ Chest Pain/Discomfort
___ Palpitations
___ Shortness of Breath

Eyes
___ Change in Vision
___ Eye Glasses
___ Contact Lens

Psychiatric
___ Anxiety/Stress
___ Sleep Problems

Neurological
___ Headaches
___ Memory Loss
___ Fainting
___ Clumsiness
___ Disorientation
___ Dizziness
___ Lack of Coordination
___ Involuntary Movement
___ Numbness
___ Paralysis
___ Tingling
___ Tremors
___ Weakness

Respiratory
___ Cough/Wheezing
___ Coughing up Blood
___ Use Oxygen Equipment
___ Use Nebulizer
___ Use CPAP/BiPap
Supplier of Equipment _____
___ Pets - How many? ____ Type: _____
Indoor/Outdoor:_____
___ Snoring
___ Daytime Drowsiness
___ Do not feel rested in the morning

Any Toxin Exposure?
___ Asbestos
___ Beryllium
___ Lead
___ Coal Dust
Other:_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates)
___ Heart disease:
Specify type _____
___ Asthma/Lung disease
___ Polyps (type) _____
___ Cancer (specify) _____
___ Liver cirrhosis
___ Ulcerative colitis/IBS
___ High blood pressure
___ Diabetes
___ Bladder/Kidney disease
___ Kidney Stones
___ AIDS
___ Blood Clots in Leg
___ Pancreatitis
___ High Cholesterol
___ Thyroid problem
___ Bleed disorder
___ Anemia
___ Hemorrhoids
___ Peptic Ulcer
Other: _____

PERSONAL SURGICAL HISTORY: Indicate whether you have had any of the following surgeries (with dates and physician's name)
___ Coronary artery bypass graft (open heart surgery)_____
___ Cholecystectomy (gallbladder removed)_____
___ Appendectomy (appendix removed)_____
___ Hysterectomy (some/all of female reproductive organs removed)_____
___ Tonsillectomy/Adenoidectomy (tonsils/adenoids removed)_____
___ Colectomy (part of the bowel removed)_____
___ Joint Replacement_____
___ Stents in Vessels_____
___ Hernia Repair (list type)_____
___ Colonoscopy_____
___ EGD_____
___ Other_____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:
Cancer (specify type)_____
Heart disease_____
Genetic disorders_____
Diabetes_____
High Cholesterol_____
High blood pressure_____
Stroke_____
Bleeding or clotting disorder_____
Asthma/COPD_____
Other:_____

SOCIAL HISTORY:
Tobacco Use
Cigarettes ___ Never ___ Quit Date _____
Current Smoker: packs/day _____ number of years_____
Other Tobacco: ___ Pipe ___ Cigar ___ Snuff ___ Chew

Alcohol Use
Do you drink alcohol? Yes/No
Number of drinks/week_____

Caffeine Use
Do you drink Coffee/Tea/Soft Drinks
Number of drinks/day_____

Signature_____ Date_____

MEDICATION SUMMARY PAGE

NAME: _____ **TODAY'S DATE:**_____

DATE OF BIRTH:_____

NAME OF PRIMARY PHARMACY AND PHONE NUMBER:_____

DRUG/FOOD ALLERGIES:

_____

_____

_____

MEDICATION NAME	**DOSE**	**FREQUENCY**

GENERAL CONSENT FORM

SOUTHEAST REGIONAL PRIMARY CARE CORPORATION AND/OR ITS AFFILIATED ENTITIES OF WHICH THIS CLINIC IS ONE

Patient: _____ DOB: _____ Today's Date: _____

I, the undersigned, agree to the following:

(1) CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent for care encompassing diagnostic, laboratory, imaging, examinations and surgical procedures and treatment by my physician, nurse practitioner (NP), physician assistant (PA) or his/her assistants, designees or consultants, as may be necessary in the judgment of my physician, NP, or PA. I also understand that I will be billed directly for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

(2) RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES

Southeast Regional Primary Care Corporation (SRPCC) and this clinic (all-encompassing and hereinafter referred to as the "Clinic") are not responsible for valuables, including money, jewelry, cell phones, glasses, dentures, documents and other personal items.

(3) RELEASE FROM RESPONSIBILITY

If I should leave the Clinic against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

(4) AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, workers compensation carriers, Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the Clinic's charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic and utilization review nurse or case manager who may not be an employee of the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as reasonably necessary to carry out treatment, payment or Clinic and/or SRPCC system of entities operations.

(5) NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the Clinic's **Notice of Privacy Practices**. My signature below acknowledges receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

(6) **ASSIGNMENT OF BENEFITS**

I hereby assign to the Clinic, or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payors for the payment of all charges associated with my treatment. I further authorize the Clinic to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the Clinic. This authorization includes, but is not limited to billing insurance, filing petitions, filing suit in name or on behalf of the Clinic or SRPCC or its assignees, filing proofs or claim, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid in excess of regular charges will be refunded as appropriate to the Third Party Payor, the patient or guarantor.

(7) **FINANCIAL RESPONSIBILITY AGREEMENT**

I understand that I am financially responsible to the Clinic and its lawful assignees for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self-insured health plans or other Third Party Payor are due and payable upon services based on the best estimates available as determined by the Clinic. Charges remaining on this account are payable upon demand. Unless payment is made in full at the time of service, then patient authorizes the Clinic or its agents to obtain a credit report. Should the account be referred for collection to a collection agency, the undersigned agrees to pay all court costs of collection may include reasonable attorney fees of up to and including 15% of the debt involved. The undersigned patient and insured also agree that the Clinic or SRPCC or its assignees may apply any payments received from the patient against any other amounts due at the time from or for the undersigned patient. All amounts not paid when due may accrue interest at the rate of 1½% per month on the unpaid principal balance. If applicable, I certify that the information provided to the Clinic in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

(8) **NON-CERTIFICATION OF SERVICES**

I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the event the insurance denies either all or part of their payment on the clinic account, I will pay the account in full upon demand.

(9) **CONSENT TO PHOTOGRAPH, VIDEOTAPE OR OTHER IMAGING**

I authorize the clinic to photograph, videotape or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I release the Clinic, its physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images.

(10) **MEDICAL EXCHANGE OF INFORMATION**

I hereby authorize the Clinic to store my information electronically and to exchange this information within the medical community (e.g. pharmacy, lab, hospital, referring provider) to continue my medical care.

(11) **METHODS OF CONTACT**

I authorize you to use and disclose Protected Health Information to contact me to remind me that I have an appointment for medical care, communicate with me regarding scheduled medical care, or to contact me to tell me about possible treatment options or alternatives or health related benefits and services that may be of interest to me. I authorize you to make this contact via any means which I have provided including, but not limited to, telephone number, wireless telephone number, voicemail, text messages, or email address(s) provided by me.

I agree, in order for you to service my account or to collect any amounts I may owe, you and/or any agents used by you, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, cell phones, voicemail, which could result in charges to me. You and/or any agents used by you, may also contact me by sending text messages or e-mails, using any e-mail address I provide to you. I acknowledge that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

(12) **PATIENT PORTAL AND EMAIL CONSENT**

I agree that I may be provided with an opportunity to participate in and/or use the Southeast Regional Primary Care Patient Portal and that the email address I provide at registration may be used for Patient Portal communications and access. I am providing consent for Southeast Regional Primary Care to communicate with me regarding my Protected Health Information via this Patient Portal. I understand that my health information is protected by federal and state law. This consent applies to records which may contain information related to the testing, diagnosis, or treatment for conditions including, but not limited to, drug and alcohol abuse; psychotherapy, mental or other behavioral health; HIV/AIDS or other communicable diseases; genetic testing; or any other condition expressly protected by Georgia Law. This consent will remain in effect unless I deactivate my (Patient Portal) account or provide written notice to Southeast Regional Primary Care Corporation.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

(13) **ACKNOWLEDGMENT**

My signature below constitutes my acknowledgment and agreement that I read and understand the above, was given the opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form's contents and significance. I understand that this consent form will be valid and remain in effect as long as I am a patient of the Clinic.

I certify that I have read the foregoing, and I am either the patient or am duly authorized by the patient's general agent to execute the above and accept the terms.

_____ _____

Signature of Patient or Authorized Individual Date

Relationship of Signer to Patient:

_____

(self, mother, father, son, daughter or explain other)

_____

Guarantor of Payment (If patient not signing)

If patient is unable to sign, state reason: _____

_____

_____ _____

Witness Date

Meadows Regional Medical Center, Inc. (MRMC), and Meadows Healthcare Alliance, Inc. (MHA), and Southeast Regional Primary Care Corporation (SRPCC) and their Affiliated Clinics and other Entities

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer:
Privacy Officer: Sandra Kate Ellington
Mailing Address: P.O. Box 1048 Vidalia, GA 30475
Telephone: (912) 538-5898
Fax: (912) 538-5510
Email: skellington@meadowsregional.org

ABOUT THIS NOTICE

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

WHAT IS PROTECTED HEALTH INFORMATION?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present or future payment for your healthcare.

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment and billing-related information. This notice applies to all of the records of your care generated by the hospital, an affiliated clinic or other entity (collectively referred to as "our organization") whether made by the hospital personnel, agents of the hospital, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office.

OUR RESPONSIBILITIES

We are required by law, including the Privacy Standards of the Health Insurance Portability and Accountability Act (HIPAA) to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

WHO WILL FOLLOW THIS NOTICE

This notice describes our organization's practices and that of:

- Any health care professional authorized to enter information into your chart.
- All departments and units of the hospital.
- Any member of a volunteer group we allow to help you while you are in the hospital.
- All employees, staff and other hospital personnel.
- Any clinic or other health care facility owned or associated with the hospital or any of its affiliated entities. All of these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or healthcare operations purposes described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following circumstances:

For Treatment: We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or health care provider has the necessary information to diagnose or treat you or provide you with a service. For example, a physician treating you for a broken leg may need to know that you have diabetes because diabetes may slow the healing process. Different departments of the hospital also may share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals and x-rays.

We may also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital/facility.

We may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

For Payment: We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

You agree, in order for us to service our account or to collect any amounts you may owe, we and/or any agents used by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and/or any agents used by us, may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

For Healthcare Operations: We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We may also disclose information to physicians, nurses, medical technicians, medical students and other authorized personnel for educational and learning purposes. And we may combine medical information we have with medical information from other hospitals to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services: We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Research: We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specifically approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required By Law: We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others, but we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates: We may disclose Protected Health Information to our Business Associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Heath Information.

Organ and Tissue Donation: If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Protected Health Information for public health activities. This includes disclosures to; (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition.

Abuse, Neglect, or Domestic Violence: We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities: We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

Law Enforcement: We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

Military Activity and National Security: If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

Coroners, Medical Examiners, and Funeral Directors: We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

We may also use and disclose medical information:

- To assess your satisfaction with our services;

- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Fundraising Activities: We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (*Optional*) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

Resident Directory: Unless you object, we may use and disclose in our hospital directory your name, your location in the hospital, your general condition and your religious affiliation. All of this information, except religious affiliation, may be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Affiliated Covered Entity: Protected health information will be made available to hospital and clinic personnel as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time.

Future Communications: We may communicate to you via mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the State privacy laws are more stringent than Federal privacy laws, the State law preempts the Federal law.

Your Written Authorization is Required for Other Uses and Disclosures:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by this revocation.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy**: You have the right to inspect and copy Protected Health Information that may be used to make decision about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with the request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by another licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Right to a Summary or Explanation:** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Right to an Electronic Copy of Electronic Medical Records:** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record,) you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable cost-based fee for the labor associated with transmitting the electronic medical record.
- **Right to Get Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Request Amendments**: If you feel that the Protected Health Information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. 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 ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Right to Request Restrictions**: You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.
- **Out-of-Pocket-Payments:** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- **Right to Request Confidential Communications**: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how and where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice**: You have the right to a paper copy of this Notice, even if you have agreed to receive this notice electronically. You may request a copy of this Notice at any time.

How to Exercise your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current notice will be made available at any admission/registration area of the hospital/facility and include the effective date. In addition, each time you register at or are admitted to the hospital/facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect. This notice is also posted on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, contact our Privacy Officer at the address listed in the beginning of this Notice. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll-free (877) 696-6755) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Other Uses of Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

List of Entities:

1. Meadows Regional Medical Center, Inc. (MRMC)
2. Meadows Healthcare Alliance, Inc. (MHA)
3. Meadows Healthcare Resources, Inc. (MHR)
4. Southeast Regional Primary Care Corporation (SRPCC)*
   *SRPCC is the owner of numerous satellite clinics and medical offices in Southeast Georgia and this notice also applies to each of the clinics.

MRMC/SRPCC NPP 2

EFFECTIVE: June15, 2015

REVISED: June 15, 2015