PRIMECARE OF GEORGIA
LIVE WELL. BREATHE WELL. FEEL WELL
1000 Towne Center Blvd, Suite 604, Pooler, GA 31322 | Phone: 912-561-7001 | Fax: 912-561-7002 | info@primecareofga.com

PATIENT DEMOGRAPHICS

Patient Name: _____
First Middle Maiden Last

Patient DOB: _____ Patient SSN: _____ Gender: ( ) Male ( ) Female

Marital Status: _____ Patient's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Home Address (if different from above): _____

Patient's (or Family Member's) Email Address: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

PERSON/PARENT RESPONSIBLE FOR ACCOUNT (other than patient):

Name: _____ Relationship to Patient: _____

Responsible Person/Parent SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION: PRIMARY

Insurance Company: _____

Insurance Cardholder's: Name _____ DOB: _____ SSN: _____

Insurance Cardholder's Address: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

INSURANCE INFORMATION: SECONDARY

Insurance Company: _____

Insurance Cardholder's: Name _____ DOB: _____ SSN: _____

Insurance Cardholder's Address: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

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NEW PATIENT INTAKE FORM

PATIENT INFORMATION- ***DATE_____***

Patient Name: _____ Date of Birth: _____ Male Female

Previous Last Name: _____ Marital Status: S M D W DP

Nickname: _____ Spouse Name: _____

Parent/Legal Guardian Name: _____

State/Country of Birth: _____ Special Communication Needs: _____

Occupation:_____ Employer: _____

Language: _____ Race: _____ Decline Ethnicity: _____ Decline

Are you a Veteran? ☐ NO ☐ YES Organ Donor? ☐ NO ☐ YES Right Handed ☐ Left Handed ☐

PATIENT CONTACT INFORMATION-

Address: _____ City: _____

State: _____Zip:_____County:_____Preferred Phone Number: _____

Is this phone number? Cell Home Work *May we leave detailed messages at this phone?* ☐ NO ☐ YES

Secondary Phone:_____ Email: _____

EMERGENCY CONTACT INFORMATION-

Name:	Relationship:	Phone Number:	Address:

I hereby authorize ***Prime Care of Georgia*** *to discuss and or release my PHI (protected health information) to:*

Name:	Relationship:	Phone:

ADVANCE CARE DIRECTIVE - Do you have an Advance Directive or Living Will? ☐ NO ☐ YES

Have you designated a Durable Power of Attorney? ☐ NO ☐ YES If yes please enter information below

Name:	Relationship:	Phone Number:	Date:

SPECIALISTS CONTACT INFORMATION- (Please provide first and last names)

Name	Office Phone	Location
Cardiologist:		
Eye Doctor:		
Gynecologist:		
Endocrinologist:		
Urologist:		
Other:		

Patient Name: _____ ***Date of Birth:*** _____

Wellness Screening History	***Date***	***Address***	***Result***
Wellness/Routine Physical Exam			
Colonoscopy			
Mammogram			
Dexa (Bone Density) Scan			
Pap Smear			
PSA			
Full Body Skin Cancer Exam			
Hepatitis C Screening			
Diabetic Eye Exam			

Adult Vaccination/Immunization History ***(If available please attach childhood immunizations separately)***

	Date		Date		Date
Tetanus		Zoster		Prevnar 20	
TDAP		Shingrix		Pneumovax 23	

Health History- Have you ever been diagnosed with any of the following: **Reconciled** ☐

☐ Measles/ Mumps	☐ Gout	☐ Seizures / Epilepsy	☐ Bone/Joint Disorder	☐ Pneumonia
☐ Chicken Pox	☐ Stomach Ulcer	☐ Parkinson's Disease	☐ Eye Disease	☐ Asthma
☐ Rheumatic Fever	☐ Reflux Disease	☐ Multiple Sclerosis	☐ Glaucoma	☐ Seasonal Allergies
☐ Scarlet Fever	☐ Gall Bladder	☐ High Blood Pressure	☐ Kidney Disease	☐ Emphysema / COPD
☐ Polio	☐ Pancreatitis	☐ Stroke	☐ Kidney Stone	☐ Pulmonary Clotting
☐ Lyme Disease	☐ Colitis	☐ Heart Disease / CAD	☐ Urinary Disorders	☐ Depression
☐ Tuberculosis	☐ Diverticulitis	☐ Heart Attack	☐ Erectile Dysfunction	☐ Anxiety
☐ Diabetes	☐ Irritable Bowel	☐ Heart Murmur	☐ Prostate Disease	☐ Eating Disorder
☐ Sleep Apnea	☐ Hepatitis	☐ Heart Failure	☐ Reproductive Issues	☐ Psychiatric Care
☐ Anemia	☐ Liver Disease	☐ High Cholesterol	☐ Menstrual Problems	☐ Drug Addiction
☐ Bleeding Disorder	☐ Thyroid Disorder	☐ Arthritis	☐ Vaginal Infection	☐ Alcoholism
☐ Blood Clot	☐ Migraines/Headache	☐ Osteoporosis	☐ Breast Lump	☐ Sexual Dysfunction
☐ Cancer Type:_____	☐ Autoimmune Disease Type:_____	☐ Peripheral Vascular Disease	☐ Skin Disease Type:_____	☐ STD Type:_____
Other Health Conditions:				
Blood Transfusion: ☐ NO ☐ YES If yes, date: Reason:				

Surgical History- *None* ☐

Procedure:	Date:

CURRENT MEDICATIONS WITH DOSAGES- *None* ☐

Allergies- ☐ No Known Drug Allergies Latex: Yes ☐ No ☐

Patient Name: _____ *Date of Birth:* _____

SOCIAL HISTORY-

Tobacco Use: ☐ YES ☐ NO ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew Amount per day: _____ Number of years you have used tobacco: _____ ☐ QUIT Years quit:_____	Alcohol Consumption: ☐ YES ☐ NO Number of drinks per week:_____ Preferred drink (ie: beer, wine, spirits): _____ ☐ QUIT Years quit:_____	Recreational Drug Use: ☐ YES ☐ NO Type: _____ Amount per week:_____ Last used:_____ ☐ QUIT Years quit:_____
Caffeine: ☐ YES ☐ NO # of caffeine drinks per day:_____	Regular Exercise: ☐ YES ☐ NO Type exercise:_____ How often:_____	Do you share a home with anyone else? ☐ YES ☐ NO ☐ Spouse ☐ ___ Children ☐__Friend
Are you regularly exposed to second- hand smoke or other potentially harmful substances at home or work? ☐ YES ☐ NO If so what?	Do you routinely need physical assistance with activities of daily living such as cooking, dressing, hygiene? ☐ YES ☐ NO	Are guns kept in your home: ☐ YES ☐ NO If yes is gun safety a priority at home? ☐ YES ☐ NO
Does everyone in your home receive all routinely recommended immunizations? ☐ YES ☐ NO	Is it important to you that you always wear your seatbelt? ☐ YES ☐ NO	Do you have working smoke detectors in your home? ☐ YES ☐ NO
Do you have regular problems with a lack of food in your home? ☐ YES ☐ NO	Do you have regular problems with transportation? ☐ YES ☐ NO	Do you have regular problems paying for the following: Housing ☐ YES ☐ NO Medications ☐ YES ☐ NO
Are you in an abusive relationship or afraid of physical harm from anyone you know? ☐ YES ☐ NO	Are you at risk of acquiring HIV infection or other sexually transmitted disease? ☐ YES ☐ NO	Do any members of your family have genetically linked health problems? ☐ YES ☐ NO

Over the past two weeks, how often have you been bothered by any of the following?

	Not at All- 0	Several Days- 1	Half the Days- 2	Nearly Every Day- 3
Little interest or pleasure in doing things				
Feeling depressed or hopeless				

If 65 years or older please answer the following:

Have you felt unsteady or fallen more than once in the past year?	Yes ☐	No ☐
Can you switch a light on/off easily from your bed without fear of falling?	Yes ☐	No ☐
Are floors and walkways in your home safe and in good repair?	Yes ☐	No ☐
Is it difficult to get out of bed or off a chair or toilet without assistance?	Yes ☐	No ☐
Is the lighting in your home sufficient for you to see safely?	Yes ☐	No ☐

FAMILY HISTORY-

Relation	Current Age, if living	Age at Death	High Blood Pressure	Heart Disease	Stroke	Cancer	Diabetes	Glaucoma	Asthma	Seizures	Bleeding Disorder
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐	☐	☐

Patient Name: _____ Date of Birth:_____

ADDITIONAL NOTES/DETAILS-

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Medicare Annual Wellness Visit Questionnaire

PATIENT DEMOGRAPHICS

Date: _____

Name: _____ _____ _____ Date of Birth: _____
Last *First* *Middle* *MM/DD/CCYY*

Home Address: _____ _____ _____ ____ _____
Street *Apt/Unit* *City* *State* *ZIP*

Gender: ☐ Female ☐ Male

Home Phone: _____ Day Phone: _____ Cell Phone: _____

SS#: _____

Next of Kin *(for emergency)*: _____

Name of Spouse: _____ Day Phone: _____

Referred by: _____

Insurance: Name: _____ Phone #: _____

Policy #: _____ Group #: _____

CURRENT MEDICAL PROBLEMS

List any current medical problems or conditions

1.) _____ 7.) _____

2.) _____ 8.) _____

3.) _____ 9.) _____

4.) _____ 10.) _____

5.) _____ 11.) _____

6.) _____ 12.) _____

PAST MEDICAL HISTORY

Childhood Illnesses

1.) _____ 3.) _____ 5.) _____

2.) _____ 4.) _____ 6.) _____

Chronic Illnesses

1.) _____ 3.) _____ 5.) _____

2.) _____ 4.) _____ 6.) _____

Last Eye / Glaucoma Exam: _____

Past Surgeries

Surgery	*Date*	*Surgery*	*Date*
1.) _____	_____	4.) _____	_____
2.) _____	_____	5.) _____	_____
3.) _____	_____	6.) _____	_____

Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY CONTINUED

List any other hospital stays

Reason	*Date*	*Reason*	*Date*
1.) _____	_____	4.) _____	_____
2.) _____	_____	5.) _____	_____
3.) _____	_____	6.) _____	_____

Physicians / practitioners you currently see

Name / Specialty	*Name / Specialty*
1.) _____	3.) _____
2.) _____	4.) _____

ALLERGIES

List any current allergies to medications, x-ray dyes or foods

Allergy	*Reaction*
_____	_____
_____	_____
_____	_____

MEDICATIONS

List any medication that you currently take, including over-the-counter

Name	*Strength*	*Direction*	*Prescribed by*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No *If yes, how much?* _____

Are others concerned about your drinking? ☐ Yes ☐ No

Diet: ☐ Balanced ☐ Vegetarian ☐ Diabetic ☐ Low salt ☐ Low fat ☐ Low carb ☐ Other: _____

Education: ☐ High school ☐ College ☐ Some college ☐ Trade school ☐ Other: _____

Do you do some form of regular exercise every day? ☐ Yes ☐ No *If yes, how much?* _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Occupation: _____

List everyone in your household, including pets:

_____	_____	_____	_____
_____	_____	_____	_____

Do you wear seatbelts? ☐ Yes ☐ No

Have you ever smoked or chewed tobacco? ☐ Yes ☐ No *If yes, how much?* _____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY CONTINUED

ROUTINE TASKS: *Please indicate if you do or do not need help performing these routine tasks*

1.) Feeding yourself	☐ Yes	☐ No	*If yes, who helps?* _____
2.) Getting from bed to chair	☐ Yes	☐ No	*If yes, who helps?* _____
3.) Getting to the toilet	☐ Yes	☐ No	*If yes, who helps?* _____
4.) Getting dressed	☐ Yes	☐ No	*If yes, who helps?* _____
5.) Bathing or showering	☐ Yes	☐ No	*If yes, who helps?* _____
6.) Walking across the room *(includes using cane or walker)*	☐ Yes	☐ No	*If yes, who helps?* _____
7.) Using the telephone	☐ Yes	☐ No	*If yes, who helps?* _____
8.) Taking your medication(s)	☐ Yes	☐ No	*If yes, who helps?* _____
9.) Preparing meals	☐ Yes	☐ No	*If yes, who helps?* _____
10.) Managing money *(like keeping track of expenses or paying bills)*	☐ Yes	☐ No	*If yes, who helps?* _____
11.) Moderately strenuous housework *(like doing the laundry)*	☐ Yes	☐ No	*If yes, who helps?* _____
12.) Shopping for personal items *(like toiletries or medicines)*	☐ Yes	☐ No	*If yes, who helps?* _____
13.) Shopping for groceries	☐ Yes	☐ No	*If yes, who helps?* _____
14.) Driving	☐ Yes	☐ No	*If yes, who helps?* _____
15.) Climbing a flight of stairs	☐ Yes	☐ No	*If yes, who helps?* _____

FAMILY HISTORY

Please list any health problems and causes of death if applicable

	Living / Deceased	*Age*	*Medical Problems*
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Mother's father	_____	_____	_____
Mother's mother	_____	_____	_____
Father's father	_____	_____	_____
Father's mother	_____	_____	_____

Patient Name: _____ Date of Birth: _____

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

Hep B *(shot)*	_____	Hearing Exam	_____
Flu vaccine *(shot)*	_____	Hemocult	_____
Pneumonia vaccine *(shot)*	_____	Lipid Panel	_____
Tetanus Diphtheria vaccine *(shot)*	_____	Mammogram	_____
Zostavax (Shingles) *(shot)*	_____	Nutritional Therapy	_____
Abdom. Aortic Aneurysm Screening	_____	Pap Smear	_____
Bone Density Scan	_____	Pelvic Exam	_____
Colonoscopy	_____	Prostate Exam	_____
Diabetes Self-Management Training	_____	PSA Test	_____
Echocardiogram	_____	Rectal Exam	_____
Eye Glaucoma Exam	_____	Smoking Cessation	_____
Glucose	_____		

HEARING

HEARING: *Check NO, YES, or SOMETIMES for **each** question*

1.) Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?	☐ Yes	☐ No	☐ Sometimes
2.) Do you feel that people are mumbling or not speaking clearly?	☐ Yes	☐ No	☐ Sometimes
3.) Do you experience difficulty following dialogue in the theater?	☐ Yes	☐ No	☐ Sometimes
4.) Do you find it difficult to understand a speaker at a public meeting or religious service?	☐ Yes	☐ No	☐ Sometimes
5.) Do you find yourself asking people to speak up or repeat themselves?	☐ Yes	☐ No	☐ Sometimes
6.) Do you find men's voices easier to understand than women's?	☐ Yes	☐ No	☐ Sometimes
7.) Do you experience difficulty understanding soft or whispered speech?	☐ Yes	☐ No	☐ Sometimes
8.) Do you have difficulty understanding speech on the telephone?	☐ Yes	☐ No	☐ Sometimes
9.) Does a hearing problem cause you to feel embarrassed when meeting new people?	☐ Yes	☐ No	☐ Sometimes
10.) Do you feel handicapped by a hearing problem?	☐ Yes	☐ No	☐ Sometimes
11.) Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?	☐ Yes	☐ No	☐ Sometimes
12.) Do you experience ringing or noises in your ears?	☐ Yes	☐ No	☐ Sometimes
13.) Do you hear better with one ear than the other?	☐ Yes	☐ No	☐ Sometimes
14.) Have you had any significant noise exposure during work, recreation, or military service?	☐ Yes	☐ No	☐ Sometimes
15.) Have any of your relatives (by birth) had a hearing loss?	☐ Yes	☐ No	☐ Sometimes

Patient Name: _____ Date of Birth: _____

DEPRESSION SCREENING

Please write your answer in the space provided

Key: ***0*** *– Not at all* ***1*** *– Several days* ***2*** *– More than half the days* ***3*** *– Nearly everyday*

1.) Little interest or pleasure in doing things _____

2.) Feeling down, depressed, or hopeless _____

FALL RISK SCREENING

Please check the appropriate answer

1.) Are you afraid of falling? ☐ Yes ☐ No

2.) Have you fallen in the past year? ☐ Yes ☐ No

If yes, circle the circumstances surrounding the fall

Answers:

Tripped over something

Lightheadedness or palpitations prior to fall

Loss of consciousness

Injured

Needed to see a doctor

Able to get up on own

ADVANCED DIRECTIVE

Do you have an Advanced Directive *(living will)*? ☐ Yes ☐ No

Notes: _____

_____

_____

Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

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Authorization for Disclosure of Health Information

All sections must be completed and legible in order for request to be processed

Patient Information:

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Release Records From: ☐ _____

Name/Facility: _____ Phone Number: _____
Address: _____ Fax Number: _____
City: _____ State: _____ Zip: _____

Release Records To: ☐ Prime Care of Georgia

Name/Facility: _____ Phone Number: _____
Address: _____ Fax Number: _____
City: _____ State: _____ Zip: _____

Information To Be Released: *Please check each item to be released

____ Clinical Notes ____ Radiology Reports ____ Labs/Pathology Reports ____ EKG ____ Immunizations
____ Hospital Notes ____ Specialist Consult Notes ____ Other: _____

Dates of Records To Be Released:

_____ to _____

____ Past 3 Months ____ Past 6 Months
____ Past Year ____ Past 2 Years
____ Past 5 Years

** Records requested for dates prior to 2011 will incur an additional fee

Reason for Request:

____ Continued Patient Care ____ Social Service/Disability ____ Insurance
____ Attorney/Legal ____ Workman's Compensation ____ Personal ____ Other: _____

How would you like your records sent:

____ Mail to address above ____ Fax to # above ____ Pick up in office

I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class or persons or facility receiving it and would then no longer be protedted by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of meon whether I sign this authorization or not. Upon receipt of requested medical records to our facility, Prime Care of Georgia will continue to protect the information under federal law.
A fee may be charged for copying the protected health information. Please contact Prime Care of Georgia to obtain fee information at 912-561-7001.
Unless otherwise revoked, this authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire automatically ninety (90) days from the date of signature.

I have read and understand the information in this authorization form.

Patient's Printed Name: _____ Patient's Signature: _____
Patient's Representative & Relation: _____ Date: _____

Office Use Only Processed by: _____ Date: _____

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PAYMENT AND FINANCIAL POLICIES

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. We have developed the following payment policies for our practice. Please read and ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. PAYMENT: Payment is expected at the time of your visit. Just as we make every effort to accommodate you when you need medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. We will accept cash, check, or credit card. We also accept FSA and HSA card payments. Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. We do ask for a copy of your current insurance card and driver's license at the time of your visit to ensure we properly file your claim.

2. CREDIT CARD ON FILE: Prime Care of Georgia is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file for our office. We will scan your card in our office and store your card number in a secure, compliant location with our credit card vendor. For security reasons, once stored, your card details will not be visible to our staff except the last four digits of your credit card number. Credit card on file will be used to pay for services that your insurance does not cover for which you are liable; this includes but is not limited to copays, co-insurance, payments towards your deductible, account balances and non-covered charges such as cancellation/no-show fees and form fees, which are still pending after your insurance processes your claim. You will receive a billing statement for any outstanding balances and will be able to make the payment in whichever way you prefer (i.e. check, credit card, cash). If we do not receive payment for the amount listed on your statement within 14 days of the statement date, we will run the credit card on file for the full amount owed 14 days after the original statement date. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied, and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement and the unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is higher, and your account will then be forwarded to a collection agency. (This clause is not applicable to patients with Peach State Health Plan/Medicaid insurance coverage).

3. INSURANCE: We participate with several insurance plans and will file your claims on your behalf. You are expected to present your insurance card at each visit. Insurance claims are filed to participating insurance companies. The patient is responsible for notifying our office of any changes in insurance coverage. Verification of participation with the patient's specific insurance plan is the responsibility of the patient. Patients are encouraged to contact our office at 912-561-7001 or their insurance carrier to ensure participation with the insurance plan prior to arriving for an appointment.

4. SELF-PAY: Payment in full is expected at the time of service for uninsured patients.

5. RETURNED CHECKS: Checks returned for insufficient funds will incur a service charge currently set at $30, which may vary from time to time as determined by our financial institution. If your check is returned, it may be represented electronically. You authorize service charges and processing fees, as permitted by state law, to be debited from the same account by paper draft or electronically, at our option.

6. PARTIAL REFUNDS: Refunds are issued to patients when a patient overpayment has occurred and there are no outstanding claims to insurance or upcoming appointments scheduled.

7. COLLECTION ACCOUNTS: All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 30 days or more after the original billing statement may be referred to a collection agency and could affect your credit.

8. FORMS FEES: Fees are to be paid when form is completed/picked up. Rates for completion of forms are as follows:

- Simple form: $10
Examples of Simple Forms: Handicap tag/sticker, College & Camp Form.

- Complex Forms: $25 (completed within 10 business days)
Examples of Complex Forms: Short Term Disability form, Long Term Disability form, FMLA Paperwork.

9. MISSED APPOINTMENTS: If you fail to cancel a previously scheduled appointment at least 24 hours in advance, this will count as a missed appointment, and you may be charged a fee as outlined below:

• $35 after the first missed appointment for a medicine new patient visit
• $25 after the first missed appointment for a medicine follow up patient
• $75 after the first missed appointment for an allergy new patient visit
• $40 after the first missed appointment for an allergy follow up patient
• $100 after the first missed appointment for a allergy skin or patch testing appointment

This charge cannot be billed to the insurance company. Failure to pay a no-show fee will be treated according to our policy on unpaid balances. This charge is not applicable to patients with Medicaid insurance coverage. Please refer to the “No/Late Show Policy” for more information.

After 3 no-show appointments in a calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

10. FINANCIAL DISMISSAL: Patients who do not make payment arrangements risk being dismissed from the practice. Prime Care of Georgia reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

QUESTIONS: We accept cash, checks, and credit card for payment. We also accept FSA and HSA card payment. For specific billing inquiries or to pay by phone with a credit or debit card, please call 912-561-7001 Monday - Friday 8AM – 5PM. Payments may also be mailed to Prime Care of Georgia, 1000 Towne Center Blvd Ste 604, Pooler, GA 31322.

I have read, understand, and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable copayments, and deductibles, are my responsibility and are payable within 14 days of the date when the billing statement is mailed.

I authorize Prime Care of Georgia to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Prime Care of Georgia. I understand and acknowledge that I am financially responsible for services rendered by Prime Care of Georgia, and I agree to pay all reasonable attorney fees and court cost in the event of default on my account.

I authorize Prime Care of Georgia to charge my credit card for any unpaid balance due on my account. I understand that my credit card on file will be charged 14 days after original billing statement is mailed.

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Patient/Guardian Signature **Date Signed**

1000 Towne Center Blvd, Suite 604, Pooler, GA 31322 | Phone: 912-561-7001 | Fax: 912-561-7002 | info@primecareofga.com

NO/LATE SHOW POLICY

Welcome to Prime Care of Georigia. The purpose of this document is to explain our practice policies regarding no-shows and late arrivals. These policies are simple and are in place to provide the best and most efficient patient care possible.

1. Please arrive 20 minutes before a new patient appointment and 10 minutes before a follow up appointment to ensure timely completion of any relevant forms.

2. Please notify us at least 24 hours in advance if you need to cancel or reschedule an appointment. Failure to do so will count as a missed appointment.

3. For Internal Medicine, a $35.00 fee may be incurred for the first missed appointment for a new patient and a $25.00 fee may be incurred for a first missed appointment and all subsequent missed appointments for follow ups for not providing the office with prior notice of cancellation at least 24 hours in advance. For Allergy and Immunology, the fees are $75 and $40 respectively. This charge cannot be billed to the insurance company. Failure to pay a no-show fee will be treated according to our policy on unpaid balances. This charge is not applicable to patients with Medicaid / Peach State Health Plans.

4. If a new patient no-shows for 3 visits, we will be unable to schedule any future appointments. If an established patient no-shows for 3 visits, we will be unable to schedule any future appointments.

5. Late arrivals of 10 minutes or more will be rescheduled to the next available appointment at the discretion of the provider. Depending on the schedule, the provider may allow a late patient to be seen at a time slot later in the same day if available.

6. We try to provide individualized care to every patient and we may sometimes run behind schedule. Please be assured that we will spend the time necessary to provide you with the best possible care.

We are here to help, so if you have any questions or concerns, please do not hesitate to contact us. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge, and understand our no/late show policy as detailed above.

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Patient/Guardian Signature **Date Signed**

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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF HEALTH INFORMATION

Which methods of communication may we use to contact you?

- ❑ Home phone – leave message to return call *without* details
- ❑ Home phone – leave message *with* details
- ❑ Cell phone – leave message to return call *without* details
- ❑ Cell phone – leave message *with* details
- ❑ Letter *with* details
- ❑ E-mail *with* details

With whom do you authorize us to discuss your health information?

NAME (please print)	RELATIONSHIP TO PATIENT	Contact Number	Date
NAME	RELATIONSHIP TO PATIENT	Contact Number	Date
NAME	RELATIONSHIP TO PATIENT	Contact Number	Date
NAME	RELATIONSHIP TO PATIENT	Contact Number	Date

THIS AUTHORIZATION MAY BE REVOKED OR REPLACED AT ANY TIME.

SIGNING THIS FORM WILL RENDER ANY PRIVIOUSLY SIGNED FORM ON FILE VOID

SIGNATURE OF PATIENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE	**DATE OF BIRTH**	**DATE**

NAME OF LEGAL GUARDIAN / LEGAL REPRESENTATIVE (*Please Print*)	**RELATIONSHIP TO PATIENT**

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CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could possibly require examination, diagnosis, and treatment. I do hereby voluntary consent to such examination, diagnosis and treatment, services, and procedures that may be recommended under the general and specific instructions of the physicians of Prime Care of Georgia, their assistants, or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of Prime Care of Georgia have made no guarantees to me as to the result of examination, diagnosis, or treatment. Prime Care of Georgia recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition.

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to Prime Care of Georgia and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that I am financially responsible for the total charges for services rendered, which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Prime Care of Georgia. I further understand that should my account become delinquent, I shall pay the responsible attorney fees or collection expenses of Prime Care of Georgia, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

INFORMED CONSENT FOR PRESCRIPTIONS

Prime Care of Georgia continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians, and pharmacists. Prime Care of Georgia's electronic health record (EHR) provides secure access for patients with commercial prescription coverage in the United States. Prescription eligibility, benefit, formulary, and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real time to pharmacists in the retail and mail order settings. I consent to electronic prescriptions and acknowledge that Prime Care of Georgia will use electronic connectivity between payers, physicians, and pharmacists.

INFORMED CONSENT FOR ELECTRONIC HEALTH RECORD (EHR) AND ELECTRONIC COMMUNICATION

Prime Care of Georgia has implemented an EHR in part to meet the U.S. Department of Health and Human Services initiative to improve health information technology, toward the goal of improving quality of health care. Our EHR integrates your clinical record with appointments, registration, and billing and makes this information available to clinicians who are involved in your health care. In connection with its electronic communication systems, Prime Care of Georgia has also implemented and has in place privacy and security policies and procedures to minimize risk of inadvertent or unauthorized disclosure, corruption and/or loss or distortion of data, but as with all record keeping systems, whether paper or digital, some risks remain of loss, inadvertent disclosure or errors in the recorded data. I have read and understand the information provided regarding the EHR, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of the EHR to carry out functions including, but not limited to electronic transfer of medical data to other medical practitioners participating in my medical care. I hereby authorize Prime Care of Georgia to use the EHR in the course of my diagnosis and treatment and consent to the electronic communication of my personal health care information to other entities for treatment, payment, or healthcare operations.

_____ _____

Patient Name **Date**

_____ _____

Patient/Guardian Signature **Relationship**

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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.
- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.
- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
- I understand that telehealth services can only be provided to patients, including myself, who are residents of or physically located in the state of Georgia at the time of this service.
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
  a) It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
  b) Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
  c) Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
- I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.
- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider. Understand that electronic communication cannot be used for emergencies or time-sensitive matters.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- By beginning the visit, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- I certify that I have read and understand this agreement and that I have had the opportunity to have questions answered to my satisfaction.

_____ _____

Patient Name **Date**

_____

Guardian Name

_____

Patient/Guardian Signature

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CONTROLLED SUBSTANCES CONTRACT

The purpose of this contract is to define the expectations between the physician and the patient regarding the use of narcotic medications.

I understand that I have a chronic pain syndrome requiring the use of narcotics for the control of the pain. In addition, I understand that the use of chronic narcotic medication carries the risk of addiction as well as side effects from the medication. I understand that narcotics may impair my ability to operate a motor vehicle or heavy equipment.

In order to reduce the chances of abuse of the medication, certain parameters regarding the prescription are agreed to:

1. I will not use the medicines at doses higher than prescribed.
2. I will not ask for or receive narcotic prescriptions from other medical providers, except as authorized by my physician.
3. I will not ask for early prescription refills except under the most adverse conditions.
4. No replacements will be provided for lost medications or prescriptions.
5. If an early refill is granted for reasons of travel, etc., the next refill will be delayed by an amount of time equal to the number of days early the refill is given.
6. I understand that my physician will need to see me for regularly scheduled visits to follow up on my chronic pain issues. It is my responsibility to schedule the appointments so that I do not run out of medication.
7. I will request medication refills as least 3 business days ahead of the time I will run out.
8. I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy to fill my pain medications and I will notify my physician if I change pharmacies.
9. I will consent to random drug testing.
10. No refills will be made at night, on holidays or weekends. I will not request refills from on-call physicians.

I have been informed that I may not take other drugs such as tranquilizers, sedatives, or antihistamines without first consulting with my physician. I understand that I should not mix my medications with alcohol. The combination use of the above drugs may produce profound sedation, respiratory depression, and in worst cases, death.

Failure to abide by these parameters will be grounds for termination of the prescription of narcotics by the physician and may result in termination from this practice.

I have read, understand, and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist.

_____	_____
Patient Name	**Physician**
_____	_____
Patient Signature	**Physician Signature**
_____	_____
Date	**Date**

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SURESCRIPTS MEDICATION INFORMATION CONSENT

What is Surescripts?
Surescripts operates an electronic network which securely connects pharmacies, care providers and benefit managers by allowing for the private electronic movement of current and historical clinical health information between different health systems, including ours here at Prime Care of Georgia. This information includes accurate histories of dispensed patient medications.

What is Medication Information and how is it used?
The Surescripts Medication History service allows healthcare professionals to access a patient's dispensed medication history across different unrelated prescribers. This service can be used in the course of providing routine health care as well as during emergencies. In both cases, accurate patient medication information enables healthcare providers to make safe, accurately informed treatment plans with their patients.

Consent
I acknowledge that by signing this form I consent to Prime Care of Georgia accessing and receiving my medication history data from the Surescripts network. I understand I may revoke this consent at any time by providing written notification to Prime Care of Georgia.

Patient Signature_____ Date:_____

Parent or Guardian_____ Date:_____

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SUMMARY OF PRIVACY PRACTICES

As a patient of Prime Care of Georgia, we want to inform you of an important protection for patient privacy that is effective as of November 28, 2021. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 permits the federal government to give practices, such as ours, specific rules about the storage and transmission of personal health care information. The Privacy Rule portion of the Act tells us how to use individually "protected health information" (PHI) about patients within our practice and how to disclose it outside our practice.

HIPAA requires that we adopt a Notice of Privacy Practices and provide you a copy. This is a lengthy Notice, so to make it easier for you to understand, we have listed the patient rights that are detailed in the attached Notice of Privacy Practices:

- Patients have the right to receive copies of our Notice of Privacy Practices
- Patients can give permission to the practice to use and disclose PHI for certain purposes and for psychotherapy notes
- Patients can ask for restrictions on certain uses and disclosures of PHI
- Patients can ask for restrictions on the way(s) in which we communicate PHI to them
- Patients can ask us to change the PHI that is contained in their medical records
- Patients can ask to inspect and copy PHI
- Patients can ask for a list of disclosures of PHI made by the practice
- Patients have the right to complain to our practice and to the department of Health and Human
- Services about alleged violations of the Privacy Practice

We fully support HIPAA and the Privacy Rule. As our patient, we ask you to sign the following Receipt Acknowledgement of our Notice of Privacy Practices, and we will be glad to provide you with a personal copy of the complete Notice if you would like to have it for your records.

Receipt Acknowledgement of Notice of Privacy Practices

_____ _____

Patient Name **Date**

_____ _____

Patient/Guardian Signature **Relationship**

TO BE COMPLETED IF THE PATIENT REFUSES TO SIGN THE ACKNOWLEDGEMENT:

Reason: _____

Employee Name: _____

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NOTICE OF PRIVACY PRACTICES

This notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable health information of the Health Insurance Portability and Accountability Act and by the amendments to the HIPAA Privacy Rules made by the Health Information Technology for Economic and Clinical Health Act of 2009 and by the final HIPAA OMNIBUS Rule.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY PROTECTED HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice on our website and in our office, in a visible location, at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors

and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost- management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this

information if the patient agrees or we are required or authorized by law to disclose this information

- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign Heads of State, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Official specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. You also have the right to restrict certain disclosures to a Healthcare Plan when you have paid out of pocket and in full for that service. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Official. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Official in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Official. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. Examples include the doctor sharing information with the nurse, or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Official. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before May 27, 2021. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Official.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Official. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to be notified of any breach of unsecured PHI. Our Practice will make all efforts to secure your PHI; however, in the event of an unsecured compromised breach, we will notify you in writing no later than 60 days following the discovery of the breach.

9. Disclosure of Genetic information. Our Practice will not use or disclose your genetic information for underwriting purposes, except where permitted for certain issuers of long term care policies.

10. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for most uses and disclosures of Psychotherapy notes, the use of PHI for marketing or fundraising

or any other purposes that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

E. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the following person/persons. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Prime Care of Georgia Privacy Officer:
Shital Patel, MD
1000 Towne Center Blvd, Suite 604
Pooler, GA 31322
912-561-7001

Secretary of the U.S. Department of Health and Human Services:
200 Independence Ave SW
Washington, D.C. 20201
877-696-6775