Rehabilitation Physicians of Georgia, P.C.

Patient Information

Name: _____ Social Security Number: _____-_____-_____

Address: _____ Date of Birth: _____ Age: _____

_____ Sex: Male Female Other: _____

Marital Status: Single Married Divorced Widowed Partner's Name: _____

Preferred name (if different than above): _____ Preferred Title/Pronouns: _____

Race: American Indian/Alaska Native Asian Black Hawaiian/Pacific Islander White Decline to answer

Ethnicity: Hispanic/Latino non-Hispanic Decline to Answer Preferred Language: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Referred by: _____ Referral Phone: _____

Insurance Information (skip if Worker's Compensation/Automobile Accident)

Primary Ins: _____ Secondary Ins: _____

Group Number: _____ Group Number: _____

Policy Number: _____ Policy Number: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Relationship to Policy Holder: Self Spouse Parent Relationship to Policy Holder: Self Spouse Parent

Worker's Compensation/Automobile Accident

Carrier Name: _____ Employer Name: _____

Claims Address: _____ Adjuster Name: _____

_____ Phone Number: _____

_____ Case Manager: _____

Claim Number: _____ Phone Number: _____

Please read and sign:

I consent to treatment by any medical professional associated with Rehabilitation Physicians of Georgia, P.C. I authorize the release of any medical information needed by a physician's office, insurance company, attorney, or hospital. I authorize payment for medical benefits directly to the provider(s) for his/her services. I understand that I am financially responsible for charges not covered by my insurance.

Patient Signature: _____ Date: _____

Rehabilitation Physicians of Georgia, P.C.

New Patient History

Patient Name: _____

Height: _____ Weight: _____ Date of appointment: _____

Reason for visit: _____

What is your pain level right now? 0 1 2 3 4 5 6 7 8 9 10

(0=No pain 10=Worst pain)

Was your pain caused by an injury? **Yes** **No** If yes, date of injury: _____

Location(s) of pain: _____

What does your pain feel like? (Circle all that apply) **Sharp** **Dull** **Burning** **Aching** **Stinging** **Throbbing** **Numbness** **Tingling**

Date when pain first began: _____ Did your pain start suddenly? **Yes** **No**

Frequency of pain: **Constantly** **Frequently** **Intermittently** **Occasionally** **Rarely** **Daytime** **Nighttime**

Severity of pain: **Mild** **Moderate** **Severe** Since it started, has your pain: **Improved** **Stayed the same** **Worsened**

What makes your pain worse? _____

What makes your pain better? _____

What does your pain keep you from doing? _____

_____

What tests have you had done regarding your pain? _____

_____

_____

What treatments, such as medications, injections, physical therapy, etc, have you received for your pain? _____

_____

_____

Please list all health problems: _____

_____

_____

Please list all surgeries: _____

_____

_____

Please list family medical history: _____

_____

_____

Are you currently working? **Yes** **No** If yes: **Fulltime** **Parttime** **Seasonally** **Self-employed**

If yes, what is your job? _____

If no, why? **Retired** **Student** **Disabled** Are you currently seeking disability? **Yes** **No**

Do you smoke? **Yes** **No** If yes, how many years and how many packs per day: _____

Do you drink alcohol? **Yes** **No** If yes, how often and how many drinks: _____

Have you used illegal drugs? **Yes, previously** **Yes, currently** **Never**

If yes, please describe your drug use: _____

_____

Do you or your family have a history of addiction? **Yes** **No**

If yes, please explain who/what/when: _____

_____

Please list all medications you are currently taking: _____

_____

_____

Please list any allergies: _____

_____

Circle all symptoms that you are experiencing

General
Chills/Fever
Weight loss/gain
Fatigue
Difficulty sleeping
General Weakness

Eyes
Eye pain
Eye discharge
Vision loss
Visual disturbance

Ears/Nose/Throat
Difficulty swallowing
Nosebleeds
Hearing loss
Neck Swelling
Vertigo

Cardiovascular
Chest pain
Palpitations
Claudication
Edema

Respiratory
Cough
Shortness of breath
Coughing up blood

GI
Nausea/vomiting
Diarrhea
Constipation
Abdominal pain

Musculoskeletal
Neck pain
Back pain
Muscle pain
Joint pain
Joint swelling
Joint redness
Joint popping
Shoulder pain
Arm pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Leg pain
Knee pain
Foot pain
Ankle pain

Skin
Rash
Skin changes
Lesions/incisions
Itching
Excessive sweating

Neurological
Headaches
Weakness
Numbness
Confusion
Memory loss
Seizure
Ataxia
Pain radiating to arms/legs
Aura

Psychiatric
Depression
Anxiety/panic attacks
Suicidal thoughts
Suicidal planning
Substance abuse
Insomnia
Inability to concentrate

Rehabilitation Physicians of Georgia, P.C.

Opioid Use Questionnaire (ORT/OUD)

*NIH/NADA Adapted

Patient Name:

Administrator:

Date Administered: Date Reviewed & Discussed with Patient:

This Tool is to be administered to patients upon initial visit prior to beginning or continuing opioid therapy for Pain Management and to current opioid patients every six months.

Please mark each box that applies.

FAMILY HISTORY OF USE	**YES**	**NO**
Alcohol	1	0
Recreational Drugs	1	0
Prescription Pain Medications	1	0
PERSONAL HISTORY OF USE		
Alcohol	1	0
Recreational Drugs	1	0
Prescription Pain Medications	1	0
Age (16-45)	1	0
PSYCHOLOGICAL		
ADHD, OCD	1	0
Bipolar, Schizophrenia	1	0
Depression	1	0
Anxiety	1	0

SCORE _____

Patient Signature_____ Date_____

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Rehabilitation Physicians of Georgia, P.C.

Pain Management Agreement (PMA)

The purpose of this Agreement is to prevent misunderstandings about certain medications you might be prescribed for pain management. This is to help you and your doctor to comply with the laws regarding prescription drugs.

I, _____, agree to use _____
(PATIENT NAME) (PHARMACY NAME)

located at _____(_____)_____,
(PHARMACY ADDRESS) (PHARMACY PHONE NUMBER)

for filling all my prescriptions from my provider at Rehabilitation Physicians of Georgia. I will be required to fill out a new PMA annually AND to change my pharmacy on record and will refrain from switching pharmacies unless necessary.

- I will communicate openly and completely with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.
- I will not use any illegal controlled substances, including, but not limited to, marijuana and cocaine; nor will I abuse alcohol while being treated. I understand and agree that I will be denied service by RPG if in their clinical judgment I am impaired by any medication and/or alcohol and that I may be required to seek alternative transportation in the event of such impairment.
- I will not share, sell, or trade my medications with anyone.
- I will not obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other doctor or clinic without RPG's knowledge and consent.
- I will safeguard my pain medication from loss or theft. **LOST/STOLEN MEDICATIONS WILL NOT BE REPLACED.**
- I understand and agree that refills of my prescriptions for pain medication will be made only at the time of an office visit during regular office hours and make take several hours for the pharmacy to receive electronically. I understand that RPG has no control over the availability of medications at my pharmacy and that my previous pickup dates are a factor in when my pharmacy will release my medications, regardless of when the prescription is issued.
- I will not miss my regularly scheduled appointments. Repeated missed appointments, late arrivals, or cancelations on the day of my appointment may subject me to fees and/or discharge from the care of RPG and its practitioners. A full copy of the Late Policy is provided to all new patients and is available by request to any existing patient.
- I understand that inappropriate or aggressive behavior in person or on the phone towards office staff, RPG providers, or patients will not be tolerated.
- I agree to submit to ongoing random urine or saliva testing, when ordered by my physician/provider to determine my compliance with my individual program of pain control in accordance with my individual Complete Risk Assessment. I agree and understand that the type & frequency of such urine or saliva testing is based on my individual Complete Risk Assessment as by my physician/provider. I also understand and agree that I may have to pay for this test at my own expense. Any inconsistent UDS is cause for dismissal.
- I agree that I will use my medication at a rate not greater or less than the prescribed rate, and that use of my medication at a greater rate will result in my being without medication until my next prescription is due.
- I will not use my medication for a purpose other than what is prescribed by my provider or to control pain other than what I am in treatment for.
- I will not inject or inhale opioids intended for oral use.
- I will follow all applicable laws as they relate to my use of controlled medications. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including Georgia's State Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations subject to applicable law. I agree to follow these guidelines that have been fully explained to me.
- All my questions and concerns regarding treatment have been adequately answered. A summary of these requirements has been given to me for my records at the initial signing and I may request a copy at any office visit.
- I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this Agreement. I understand that if I break any portion of this Agreement, my doctor will stop prescribing these pain control medications and my actions could lead to the permanent termination of the relationship with my doctor and RPG.

This Agreement is entered into on this _____ day of _____, 20_____.

Patient's Signature: _____

Provider's Signature: _____

Supervising Physician (for PAs and NPs): Joyce Akwe, MD Mark W. Feeman, DO Ernest L. Howard II, MD Youl Yee Kim, MD

Rehabilitation Physicians of Georgia, P.C.

Pill Count Agreement

Patient Name: _____ Date of Birth: _____

Your RPG healthcare providers understand that your pain is a hindrance to the quality of your life. We are here to help you.

The purpose of this Agreement between you and your Provider is to prevent misunderstandings and set expectations associated with the use of certain pain medicines, diagnostics, and therapies that may be prescribed to help you manage your pain.

As part of your Pain Management Agreement, your provider has requested to perform pill counts for your prescribed medication. Your provider can call you in for random pill counts. Failure to comply with pill count will lead to discharge from the practice.

This Agreement is entered into on this _____ day of _____, 20_____.

Patient's Signature: _____

Provider's Signature: _____

Supervising Physician (for PAs and NPs): Joyce Akwe, MD Mark W. Feeman, DO Ernest L. Howard II, MD Youl Yee Kim, MD

Rehabilitation Physicians of Georgia, P.C.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

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

I understand that as part of my health care, Rehabilitation Physicians pf Georgia, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my heath information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Rehabilitation Physicians of Georgia, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Rehabilitation Physicians of Georgia, P.C reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Rehabilitation physicians of Georgia, P.C. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I request the following **RESTRICTIONS** or **AUTHORIZATION** (circle one) to the use or disclosure of my health information.

Name	Relationship
1. _____	
2. _____	
3. _____	

I understand that as part of RPG's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully **ACCEPT** or **DECLINE** (circle one) the terms of this consent.

This Agreement is entered into on this _____ **day of** _____, 20_____.

Patient's Signature: _____

Rehabilitation Physicians of Georgia, P.C.

Financial Policy and Consent

Patient Name: _____ Date of Birth: _____

Rehabilitation Physicians of Georgia, PC (RPG) recognizes the need for a clear understanding between the patient and medical provider regarding financial arrangements for healthcare and protected health information. The following information is provided to avoid any misunderstanding concerning payment for professional services and protected health information.

Payment: Payments are required at the time of service; this includes any insurance copays. Checks cannot be accepted for payment, only cash or debit/credit card payments will be accepted. Change cannot be provided on cash payments. If exact change is not provided, any overage will be applied as a credit to the patient's account. For convenience, RPG will file the patient's valid, active insurance. Even though the patient's insurance will be filed, he or she is responsible for any balance after insurance processes the claim. The patient is also responsible for any coinsurances and/or unmet deductible amounts; any overpayment of coinsurances/unmet deductible amounts will not be refunded but added as a credit to the patient's account. Payment arrangements for billed services must be approved by Kelly O'Neal, RPG billing manager. If no payment arrangements have been made or payment has not been received within ninety (90) days of the initial billing statement date, the patient's account will be filed under a "collections status," and the patient will not receive any additional treatment (including refills) until payment is made in full.

Secondary Insurance: The state of Georgia requires the patient to provide secondary insurance coverage to providers if applicable. The patient agrees to provide such information. The patient agrees to notify RPG of any additions, deletions, or other changes to the policy coverage: this includes both primary and secondary insurance policies.

Self-Pay (private, cash pay): All self-pay patients are required to pay fees at the time of service. This may include any additional service fees such as, but not limited to, in-office injections and urine drug screens. If a patient is considered self-pay at the time of service and then receives insurance, RPG will not reimburse any previously paid fees at the self-pay rate.

Please note, RPG will NOT retroactively file insurance, with the exception of Medicaid.

The following charges apply to ALL patients:

Medical Records: In accordance with RPG practice policy, a processing fee of $25.00 (not payable by insurance) can be charged. Please allow up to ten (10) business days for request processing.

Missed/Late Appointments: A minimum notice of 24-hours is required for cancellation of office visits. A fee of $25.00 can be charged for missed appointments without prior sufficient notice. EMG/NCS are subject to individual cancelation policies and fees, and you will be provided with those policies when/if such an appointment is scheduled for you. Late/missed appointment fees are not billable to insurance and must be paid prior to services in addition to any other copayments, co-insurance, or deductible due.

RPG firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need additional information or clarification regarding these policies, please call our billing director, Kelly at 770-985-6936. By signing below, you agree to the terms and conditions of the RPG financial policy and provide your consent regarding outlined policies.

This Agreement is entered into on this _____ day of _____, 20_____.

Patient's Signature: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

Rehabilitation Physicians of Georgia, P.C.

I, _____, have been made available a copy of
Patient Name

Rehabilitation Physicians of Georgia, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient Date

A copy of the Rehabilitation Physicians of Georgia Privacy Practices is in your paperwork to take home at the back of this New Patient Packet.

There are copies available in all of our offices at any visit and a digital format can be found online at www.attackback.com.

Rehabilitation Physicians of Georgia, P.C.

Informed Consent Regarding After Hours Phone Calls

Patient Name: _____ Date of Birth: _____

Our Practice specializes in chronic musculoskeletal pain management and is not an urgent care or emergency medicine clinic. Any calls after normal clinic hours 8am-4pm Monday-Friday, excluding major holidays, regarding emergent care requirements are to be directed to 911 or the closest emergency department.

All calls made to our practice when the clinics are closed will be returned the next business day. Leaving multiple voicemails will potentially slow the process while staff works to listen to and follow up on each message.

It is possible, during the course of your relationship with the practice, that you might be given a cell phone number for your provider or other staff members. This method of contact is subject to the same rules regarding office hours availability and is only to be used at the time it is provided or as otherwise directed by the staff member.

Digital communication including RPG email and text messages to staff are also subject to the rules regarding office hours availability and are not to be used in lieu of calling the office directly unless you are directed to do so. The correct and most direct method of reaching someone regarding your care is always to call the office and speak with someone or leave a voicemail for a return call.

Digital communication including personal email accounts, social media, and all other forms of contact not specifically listed are NOT protected communications and are considered a violation of this agreement.

Repeat communication violations can result in being discharged from care for harassment of staff.

This Agreement is entered into on this _____ day of _____, 20_____.

Patient's Signature: _____

Provider's Signature: _____

Supervising Physician (for PAs and NPs): Joyce Akwe, MD Mark W. Feeman, DO Ernest L. Howard II, MD Youl Yee Kim, MD

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Rehabilitation Physicians of Georgia, P.C.

Urine Drug Screen Payment Policy

Patient Name: _____ Date of Birth: _____

Urine Drug Screens (UDS) are performed periodically per state regulations and as your health care provider deems necessary. While it is our priority to utilize the preferred lab of your health insurance policy, this cannot be guaranteed. If you are aware of the preferred lab of your health insurance policy, please make your provider and his/her medical assistant aware of this information. If your health insurance policy denies the charges for the UDS due to usage of a non-preferred lab, you will be responsible for a $25 charge. The $25 charge will be the only charge from Rehabilitation Physicians of Georgia, PC. If you receive a bill from the laboratory, you will need to contact the laboratory company's billing department regarding any outstanding charges.

Informed Consent Regarding In-House Laboratory Services

Our Practice utilizes owned laboratory equipment. Should you choose not to use out laboratory, please inform us immediately and provide us with the necessary information to access your preferred lab. Please be aware that choosing your preferred lab does not preclude RPG from ordering and requiring certain laboratory testing as part of your health care plan, nor does choosing an alternate laboratory company obligate your insurance company to cover the testing at the same rate or at all. This may mean that you receive separate billing from preferred laboratories and RPG has no determination over the cost of those services to you.

Rehabilitation Physicians of Georgia, PC utilizes labs owned by LabCorp and Quest for UDS and Paradigm for Oral Drug Screens.

By signing below, you attest that these policies have been explained to you and that you have read and understood your personal responsibilities, that you have had adequate time to review the policies, and that all questions pertaining to the policies have been answered. Furthermore, you attest that you have been provided with a copy of this form if requested. The original will be placed in your medical record.

This Agreement is entered into on this _____ day of _____, 20_____.

Patient's Signature: _____

Preferred Laboratory (optional)

Laboratory Name: _____

Is this lab preferred and/or required by your insurance company? Yes No Unsure

Rehabilitation Physicians of Georgia, P.C.

Patient Emergency Contact Consent

Patient Name: _____ DOB: _____

To ensure that we have the most current information for your care, please designate an emergency contact that we may call if you experience a medical crisis while in one of our offices or if we are unable to reach you about your care. All attempts will be made to contact you directly prior to involving your EC, however it sometimes becomes necessary in the course of care to make prompt contact.

THIS IS NOT A MEDICAL RECORDS RELEASE. NO PROTECTED INFORMATION BESIDES YOUR NAME, DATE OF CARE, AND EMERGENCY TREATMENT PROVIDED (IF APPLICABLE) WILL BE RELEASED TO THE PERSON YOU LIST ON THIS DOCUMENT.

If you need to update your Disclosure of Information Consent or authorize a Medical Records Release, please ask the staff for those separate documents during your visit.

Emergency Contact: _____

Relationship: _____ EC Phone Number: _____

_____ _____

Signature of Patient Date

Rehabilitation Physicians of Georgia, P.C.

Your Pain Management Agreement Says:

1. I will tell the truth about my pain and how my medication(s) work(s) for me.

2. I will not use any illegal drugs. If I come to the office under the influence, as decided by my provider, I may be denied my prescriptions.

3. I will not share, sell, or trade my medication(s).

4. I will not get any other narcotics from any other provider than RPG.

5. I will keep my medication safe because I know they will not be replaced before the next refill due date.

6. My medications will only be refilled at my regular follow up visits, which I will not miss.

7. Aggressive behavior towards staff, patients, or other people in the office, as decided by the RPG staff, will not be tolerated. Abusive language over the phone or in voicemails will not be tolerated.

8. I will have regular urine or saliva drug screens and may have to pay for this testing.

9. I will use my medication(s) as prescribed by my provider. If I run of out my medication(s) early, I am not entitled to early refills.

10. I will not inject, inhale, or abuse my medications.

11. I will follow all laws, as they apply to my use of controlled substances.

12. I will allow my provider and pharmacy to cooperate with any law enforcement agency in the investigation of any possible misuse, sale, or diversion of my medication(s).

Failure to comply with the above rules and all other agreed upon policies may result in my dismissal from the care of Rehabilitation Physicians of Georgia, PC.

PLEASE KEEP THIS PAGE FOR YOUR REFERENCE.

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Rehabilitation Physicians of Georgia, P.C.

Late Appointment Policy

Our doctors, medical assistants and staff aim to make your visit a smooth one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is more than 10 minutes late for an appointment, the appointment will be rescheduled. This is to ensure that patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our other patients. Tardiness and missed appointments affect the care of **ALL** the patients in the office, not just your own care with RPG.

The doctors and staff at Rehabilitation Physicians of Georgia appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.

New Patients are required to show up 30 minutes prior to their scheduled appointment time to allow for completion of paperwork, ID verification, and to answer any questions about the paperwork or flow of care. Failure to do so will result in rescheduling your appointment.

New Patient Example

Scheduled Appointment Time: **10:00 AM**

Specified Arrival Time: **9:30 AM**

Arriving **after 9:40 AM** will result in the appointment being marked as "Missed" and being rescheduled.

Returning Patient Example

Scheduled Appointment Time: **10:00 AM**

Arriving **after 10:10 AM** will result in the appointment being marked as "Missed" and being rescheduled.

PLEASE KEEP THIS PAGE FOR YOUR REFERENCE.

Rehabilitation Physicians of Georgia, P.C.

Medical Records Release Policy and Procedure

In response to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, physicians have been faced with greater complexities when releasing medical records. To protect patient confidentiality, as well as comply with government regulations, Rehabilitation Physicians of GA., has developed policies and procedures to ensure that your confidential medical records are handled in a manner meeting all necessary guidelines. Medical Records will be released only upon written request from the patient. Written requests must be in accordance with the Uniform Health Care Information Act. Rehabilitation Physicians of GA will only release records that were created and maintained by our doctors and clinic. We will not release records received from other clinics or providers.

The requirements for a valid authorization to release medical records are:

- In writing, dated and signed by patient, from the requesting office.
- Specifically identifies patient
- Specifically identifies the healthcare provider who is to make the disclosure
- Specifically identifies the information to be disclosed

Note:
An authorization which affects a medical record in which information concerning the performance or results of HIV/AIDS status, STD testing, substance abuse, and mental/psychiatric treatment must specifically authorize the release of such tests and/or treatment information or it will be excluded from the records release.

If you need your Medical Records, please refer to our policy for collecting below.

- **Notes for one office visit:** should be collected at your visit, if available, or at your next visit.
- **Complete chart:**
  - By the patient: please contact Amy at 404-659-5909 ext. 203.
  - By a medical facility, attorney, claims adjuster, or other authorized party: please request in writing by fax at 770-399-9449
  - Please note, fees can be charged.
- **If you have been discharged:** Your notice of discharge will include your most recent three office visit notes. Other records can be mailed to your home or requested by your new provider. Contact Amy at 404-659-5909 ext. 203 for additional assistance.

PLEASE KEEP THIS PAGE FOR YOUR REFERENCE TO EXPEDITE FUTURE NEEDS.

EXHIBIT 3:

Rehabilitation Physicians of Georgia, P.C.
NOTICE OF PRIVACY PRACTICES EFFECTIVE April 29, 2014

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

You have the right to a paper copy of this Notice; you may request a copy at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

We may use and disclose your health information for the following purposes without your express consent or authorization.

Treatment. We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to persons outside our organization involved in your treatment, such as other health care providers, family members, and friends.

We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying our organization and asking for you to return our call. We will not disclose any health information to any person other than you except toleave a message for you to return the call.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health planwith which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. We provide some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

Creation of de-identified health information. We may use your health information to create de- identified health information. This means that all data items that would help identify you are removed or modified.

Uses and disclosures required by law. We will use and/or disclose your information when required by law to do so.

Disclosures for public health activities. We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person whomay have been exposed to a communicable disease if permitted by law.

Disclosures about victims of abuse, neglect, or domestic violence. We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for law enforcement purposes. We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures regarding victims of a crime. In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to avert a serious threat to health or safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Disclosure for fundraising. We may disclose demographic information and dates of service to an affiliated foundation or a business associate that may contact you to raise funds for our organization. Youhave a right to opt out of receiving such fundraising communications.

Disclosure for remunerated treatment communications. We may disclose your information for the purposes of communicating treatment alternatives or health-related products or services when we receive payment for your information in exchange for making the communication. You have a right to opt out of receiving such communications.

OTHER USES AND DISCLOSURES

We will obtain your express written authorization before using or disclosing your information for any other purpose not described in this notice. For example, authorizations are required for use and disclosureof psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent we have notrelied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right to Inspect and Copy. You have the right to inspect and copy health information maintained by us. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right To Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

Right to an Accounting of Disclosures and Access Report. You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. You also may request an access report indicating who has accessed your PHI maintained by us or our business associates in an electronic designated record set in the last three years. To request an accounting, you must complete a specific written form providing information we need to process your request.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific written form providing information we need to process your request. Our Privacy Officer is the only person who has the authority to approve such a request.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. Our Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Executive Assistant, Amanda Coker at 2450 Atlanta Highway, Suite 904, Cumming, GA 30040. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

We reserve the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.