THOMAS NEUROPSYCHOLOGY
DIAGNOSTICS & CONSULTING

Brian Thomas, Psy.D., ABPP/ Board Certified in Clinical Neuropsychology
144 South Thomas Street Suite 104A /Tupelo, MS 38801

Thank you for considering Tele-Health for your interview with Thomas Neuropsychology. We are doing our best to meet the needs of our patients as well as follow social distancing guidelines to reduce the risk of the COVID-19 virus.

Attached you will find a packet containing:

1) Tele-Health consent
2) Patient Information pages Lots of places to sign/initial and date. We've hi lighted some. Please complete fully.
3) Office Practices and HIPAA Guidelines
4) **Instructions for Google Meet**

Please fill out the 1). Tele-Health consent and 2). Patient Information pages in their entirety. (Page 3 has a space for you to put your referring doctor's name.)

Make a copy **OR** screenshot of your insurance cards as well as your photo identification.

Return **ALL** information to us by **ONE** of the following: **We only need back the pages you write on**

Email: drbrianthomas@drbrianthomas.com (*We cannot guarantee the security of any information exchanged by email.)

OR Fax: 662-259-8479

OR USPS Mail to:
Thomas Neuropsychology
144 South Thomas Street
Suite 104A
Tupelo, MS 38801

When we receive the completed information; we will either call you or email your appointment time with the doctor. **Please note that the doctor will be calling you at your appointment time from an "undisclosed" phone number.

Office Phone number: (662) 231-8916

Thank you and Stay Well!

The Office at Thomas Neuropsychology

Telebehavioral Health Information Sheet:
In response to the current Coronavirus/COVID-19 outbreak and recommendations to protect public health, Thomas Neuropsychology will be utilizing interactive technologies (use of audio, video or other electronic communications) between the practitioner and the client/patient who are not in the same physical location. Because patients are often located in an area where high speed internet is not available and due to the increased demand on internet services, providers will be providing the service by use of a telephone contact.

You may decline any telebehavioral health services at any time without jeopardizing your access to future care, services, and benefits.

Risks of Technology:
These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Exchange of Information:
The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

Emergency Procedures:
In the event of a clinical emergency, such as serious thoughts of suicide, you should call **911.** Alternatively, patients can call your local emergency room.

Disruption of Service:
Should service be disrupted the Provider will contact you at your preferred number provided.

Client Communication:
It is your responsibility to maintain privacy on the client end of communication. The provider will take steps to ensure privacy at the provider's site. Both parties accept that part of the inherent risks of telebehavioral services is the risk for disruptions, dropped communication, and privacy breaches. Neither the patient, provider, or anyone associated with the patient or provider will store or record audio or video session data.

Please make sure you are in a room where you can talk freely and where you will not be disturbed at any time during the session. If you have a small child, dog, cat or other pet, please make sure they are taken care of, in advance so they do not disrupt the session. Please turn off any instant notifications on your device for the duration of the session.

Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications. Given recent directives by federal government in response to the Coronavirus outbreak, it is our understanding that insurance carriers have been instructed to cover telehealth visits in the same way as in-person visits. For additional information and to verify benefits, please contact your insurance carrier.

Laws & Standards: The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

To receive telehealth services, the patient agrees that he/she will receive these services while the patient is located within the state of MS.

Confirmation of Agreement: _____

Client Printed Name _____

Signature of Client or Legal Guardian Date _____

Printed Name of Practitioner _____

_____
Signature of Practitioner

_____
Date

Brian Thomas PSY.D, PLLC/ Thomas Neuropsychology

Patient Information

BIRTHDATE (MONTH/DAY/YEAR) :_____ SS#:_____

Sal: Mr., Mrs., Ms., Dr., Rev., Fr. _____
Last First MI Suffix

Address:_____
Street/P.O. Box City State ZIP

Home#:_____ Cell#:_____ E-mail address:_____

Sex:_____ Race:_____ Marital Status:_____ Spouse/S.O. Name:_____

Employer:_____
Name Address Phone#

School Name (if applicable):_____

Emergency Contact:_____
Name Phone#

Insurance Information/ Please check here if no insurance _____

Primary Insurance Carrier_____ Secondary Insurance Carrier_____

Address # 1_____Address # 2_____

Insurance ID # Primary_____ Grp#_____ Insurance ID # Secondary_____ Grp#_____

Guarantor's name if other than patient_____/_____

Guarantor's Birthdate: ____/____/_____SS#: _____ Relationship to Guarantor_____

Method of Payment (for co-pays, co-insurance or self pay)

Circle One: Cash Check Debit/Credit (Visa/Mastercard/Discover)

Authorization to Release Information

I authorize Brian Thomas PSY.D PLLC/Thomas Neuropsychology and any other holder of medical information to release this information as necessary to process this and any future claims to my insurance carrier, Medicare, Medicaid any fiscal carrier of such and any other entity as needed to determine benefits and to receive benefits as payable.

Assignment of Benefits and Financial Responsibility

I request and authorize payment of all medical benefits to Brian Thomas PSY.D PLLC for services provided. I request that payment of authorized benefits of Medicare, Medicaid or any other carrier be made on my behalf to Brian Thomas PSY.D PLLC for this and all future visits. I understand that it is my responsibility to verify my coverage for services provided by a Psychologist and I will be liable for any amounts denied by my insurance company for such services. I also agree to pay any amount due to Brian Thomas PSY.D PLLC as deemed eligible after insurance payments have been exhausted.

Notice of Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Collections

I understand any amount not paid by the insurance carrier that is deemed my responsibility will be billed to me and 1 am responsible for that balance in full. I understand if I fail to pay the balance due then that balance will be turned over to an outside collection agency. A COLLECTION FEE of 35% will be added to the total and that the account can be reported to credit bureaus and legal action may be taken against me.

Signature of Patient or Patient's Representative_____Date _____

BRIAN THOMAS PSY.D, PLLC/Thomas Neuropsychology

CONSENT FORM

Patient's Name_____ **DOB**_____

I, the undersigned, agree to the following: ***(Initial boxes after reading)***

Consent for Psychological Treatment

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my psychologist, his assistant, designees or consultants, as may be necessary in the judgment of my psychologist. I also understand that I will be billed direct for those services provided. I am aware that the practice of psychology is not an exact science and I acknowledge that no guarantees have been made as to the results of treatments or examinations in this clinic. I understand that my medical record may be maintained on a computer based system and is available to persons involved in my care. _____**Initials**

Limits to Confidentiality

I understand that my information is treated as strictly confidential and under ordinary circumstances cannot be transmitted to any other person without my prior written consent to do so. However, Brian Thomas Psy.D PLLC/Thomas Neuropsychology is obligated by law to disclose, and not necessarily with my consent, information about me to another party including but not limited to emergency services including 911 and abuse hotlines, parties who may be at risk, under the following circumstances:

1. Any abuse of a minor, individual with a disability, or an older adult
2. Any threat of harm to myself or another individual.

In these circumstances, I understand that the staff may contact any third party that is/are deemed necessary to protect my safety or that of another person.

Furthermore, I understand that my records from Brian Thomas Psy.D PLLC/Thomas Neuropsychology are subject to court subpoena. I understand that should a court subpoena all of, or any portion of, my records from Brian Thomas Psy.D PLLC/Thomas Neuropsychology, Brian Thomas Psy.D PLLC/Thomas Neuropsychology may submit these records to the court. Again, Brian Thomas Psy.D PLLC/Thomas Neuropsychology will consider all information provided by me as privileged and confidential information, and except as noted in the situations above, will not release any information about me or my records to any individual or agency without obtaining my prior approval in the form of a signed authorization. _____**Initials**

Release from Responsibility

If I should leave the clinic against psychological advice or prior to treatment being completed, I hereby relieve said psychologist and the clinic of all liability for my action. _____**Initials**

Authorization for Release of Medical Information

I authorize the clinic's designee to release to the payors/insurers herein specified, Health Care Financing Administration, or to any other insurer or agency concerned with payment of my charges, any and all medication information, related to clinic services which are deemed by the payors/insurers other agencies, to be required in the processing of applications for financial coverage for services rendered. I authorize release of my medical records to either health care organizations consulted by my psychologist.
_____**Initials**

PF-3000 (b) Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Clinic Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. _____**Initials**

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ **DOB:**_____ **Patient ID:**_____

I hereby authorize Brian Thomas PSY.D PLLC/Thomas Neuropsychology to use or disclose my protected health information as indicated below to:

_____NONE
_____EMPLOYER
___XX_OTHER HEALTH CARE PROVIDERS (specify names) _____
_____OTHER ANCILLARY PROVIDERS

this is the name of the provider who referred you to us.

OTHER INFORMATION TO BE RELEASED:

___XX_Psychological / Neuropsychological Evaluation Report
_____LAB REPORT
_____X-RAY REPORT
___XX_CONSULTATION REPORT
___XX_MENTAL HEALTH RECORDS

PURPOSE OF DISCLOSURE:

_____LEGAL
__XX_ INSURANCE
_____SCHOOL
_____SECOND OPINION
_____EMPLOYER REQUEST

1. I understand that this authorization will expire **two years from my last date of service visit.** A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Brian Thomas PSY.D PLLC/Thomas Neuropsychology in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My healthcare and payment for my healthcare will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present and future treatment for psychological disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I can have a copy of this form if I request one, after I have signed it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient:_____ **Date:**_____

I hereby give my consent for Brian Thomas PSY.D PLLC/Thomas Neuropsychology to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The notice of Privacy Practices provided by Brian Thomas PSY.D PLLC/Thomas Neuropsychology describes such as uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Brian Thomas PSY.D PLLC/Thomas Neuropsychology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: **Brian Thomas PSY.D PLLC/Thomas Neuropsychology**

144 S Thomas St, Ste 104 A
Tupelo, MS 38801

With this consent, Brian Thomas PSY.D PLLC/Thomas Neuropsychology **may call** my home or other alternative location and leave a message on voicemail (unless a Refusal to Allow Voice Mail Form is completed) or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Brian Thomas PSY.D PLLC/Thomas Neuropsychology **may mail** to my home or other alternative location any item that assist the practice in carrying out TPO such as, appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Brian Thomas PSY.D PLLC/Thomas Neuropsychology **may e-mail** my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Brian Thomas PSY.D PLLC/Thomas Neuropsychology restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by agreement. By signing this form, I am consenting to allow Brian Thomas PSY.D PLLC/Thomas Neuropsychology to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, Brian Thomas PSY.D PLLC/Thomas Neuropsychology may decline to provide treatment to me.**

Print Patient's Name_____ **Signature of Patient or Legal Guardian**_____

Date_____ **Printed Name of Legal Guardian (if applicable)**_____

Notice of Privacy Practices Acknowledgement – HIPAA
Authorization for Release of Personal Health Information

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.
My acknowledgement does not indicate agreement, only that I was offered a copy which I [ ] accepted, [ ] declined.

_____ _____
Signature of Patient Date

When Patient is a minor or incompetent to sign acknowledgement:
I acknowledge that I have been offered a copy of the Notice of Privacy Practices on behalf of a patient. My acknowledgement does not indicated agreement, only that I was offered a copy which I [ ] accepted, [ ] declined.

_____ _____ _____
Signature of Patient Representative Date Relationship to Patient

When Patient or Authorized Person Refuses to Sign Acknowledgement:
Patient (or Patient Representative) was offered a copy of the Notice of Privacy Practices which they: [ ] accepted, [ ] declined, but refused to sign the acknowledgement.

_____ _____
Employee Date

Disclosure of Personal Health Information:

We will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list names and relationships of those you authorize us to discuss your personal health information:

Contact Name(s):	Relationship:	Daytime Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____

[ ] Patient/Representative did not list anyone.

Patient/Guardian: _____ _____
Print Name Date

_____
Signature

Name _____

Date _____

Please provide the following information regarding the medication you are currently taking:

Name of Medication	Dosage	Frequency taken	How taken (orally, injection)

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

Notice of Privacy Practices

Privacy is a very important concern for all those who come to this office. It is also complicated because of the many federal and state laws and our professional ethics. Because the rules are so complicated some parts of this Notice are very detailed and you probably will have to read them several times to understand them. If you have any questions our Privacy Officer will be happy to help you understand our procedures and your rights. His or her name and address are at the end of this Notice.

Contents of this Notice

A. Introduction - To our clients

This Notice will tell you how we handle your medical information. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. Because the laws of this state and the laws of federal government are very complicated and we don't want to make you read a lot that may not apply to you, we have removed a few small parts. If you have any questions or want to know more about anything in this Notice, please ask our Privacy Officer for more explanations or more details.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or any other what are called "healthcare providers" information is collected about you and your physical and mental health. It may be information about your past, present or future health or conditions, or the tests and treatment you got from us or from others, or about payment for healthcare. The information we collect from you is called, in the law, PHI, which stands for Protected Health information. This information goes into your medical or healthcare record or file at office. In this office this PHI is likely to include these kinds of information:

Your history. As a child, in school and at work, marriage and personal history.

Reasons you came for treatment. Your problems, complaints, symptoms, or needs.

Diagnoses. Diagnoses are the medical terms for your problems or symptoms.

A treatment plan. A list of the treatments and any other services which we think will be best to help you.

Progress notes. Each time you come in we write down some things about how you are doing, what we notice about you, and what you tell us.

Records we get from others who treated you or evaluated you. Psychological test scores, school records, and other reports. Information about medications you took or are taking.

Legal matters. Billing and insurance information.

This list is just to give you and idea and there may be other kinds of information that go into your healthcare record here. We use this information for many purposes. For example, we may use it:

To plan your care and treatment

To decide how well our treatments are working for you.

When we talk with other healthcare professionals who are also treating you such as your family doctor or the. professional who referred you to us.

To show that you actually received the services from us which we billed to you or to your health insurance company.

For teaching and training other healthcare professionals.

For medical or psychological research.
For public health officials trying to improve health care in this area of the country.
To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for you can make better decisions about who, when, and why others should have this information. Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You can read it and if you want a copy we can make one for you (but may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations you cannot see all of what is in your records. *If you find anything in your records that you think is incorrect or believe that something important is missing you can ask us to amend (add information to) your record, although in some rare situations we don't have to agree to do that. If you want, our Privacy Officer, whose name is at the end of this Notice, can explain more about this.

C. Privacy and the laws

We are also required to tell you about privacy because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The H1PAA law requires us to keep your Protected Healthcare Information (or PHI) private and to give you this notice of our legal duties and our privacy practices, which is called the Notice of Privacy Practices (or NPP). We will obey the rules of this notice as long as it is in effect but if we change it the rules of the new NPP will apply to all the PHI we keep. If we change the NPP we will post the new Notice in our office where everyone can see. You or anyone else can also get a copy from our Privacy Officer at any time.

D. How your protected health information can be used and shared

When your information is read by me or others in this office and used by us to make decisions about your care that is called, in the law, If the information is shared with or sent to others outside this office, that is called, in the law, Except in some special circumstances, when we use your PHI here or disclose it to others we share only the minimum necessary PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used and to have a say in how it is disclosed (shared) and so we will tell you more about what we do with your information. We use and disclose PHI for several reasons. Mainly, we will use and disclose it for routine purposes and we will explain more about these below. For other uses we must tell you about them and have a written Authorization from unless the law lets or requires us to make the disclosure without your authorization. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures of PHI in healthcare with your consent

After you have read this Notice you will be asked to sign a separate Consent form to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share your PHI with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called health care operations. Together these routine purposes are called TPO and the Consent form allows us to use and disclose your PHI for TPO. Take a minute to re-read that last sentence until it is clear because is very important. Next we will tell you more about IPU.

la. For treatment, payment, or health care operations.

We need information about you and your condition to provide care to you. You have to agree to let us collect the information and to use it and share it to care for you properly. Therefore you must sign the Consent form before we begin to treat you because if you do not agree and consent we cannot treat you. When you come to see us, several people in our office may collect information about you and all of it may go into your healthcare records here. Generally, we may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called healthcare operations. Let's see what these mean.

For treatment. We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services. We may share or disclose your PHI to others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team we can share some of your PHI with them so that the services you receive will be work together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record and so we all can decide what treatments work best for you and make up a Treatment Plan. We may refer you to either professionals or consultants for services we cannot provide. When we do this we need to tell them some things about you and your conditions. We will get back their findings and opinions and those will go into your records here. If you receive treatment in the future from other professionals we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others so we can be paid for the treatments we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions, We will need to tell them about when we met, your progress, and other similar things.

For health care operations. There are a few other ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

1b. Other uses in healthcare

Appointment Reminders. We may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment Alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other Benefits and Services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your information to do research to improve treatments. For example, comparing two treatments for the same disorder to see which works better or faster or costs less. In all cases your name, address and other personal information will be removed from the information given to researchers. If they need to know who you are we will discuss the research project with you and you will have to sign a special Authorization form before any information is shared.

Business Associates. There are some jobs we hire other businesses to do for us. In the law, they are called our Business Associates. Examples include a copy service we use to make copies of your health records and a billing service who figures out, prints, and mails our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy they have agreed in their contract with us to safeguard your information.

2. Uses and disclosures that require your Authorization

If we want to use your information for any purpose besides the TPO or those we described above we need your permission on an Authorization form. We don't expect to need this very often. If you do authorize us to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time we will not use or disclose your information for the purposes that we agreed to. Of course, we cannot take back any information we had already disclosed with your permission or that we had used in our office.

3. Uses and disclosures of PHI from mental health records that don't require a Consent or Authorization

The laws lets us use and disclose some of your PHI without your consent or authorization in some cases. Here are examples of when we might have to share your information.

When required by law. There are some federal, state, or local laws which require us to disclose PHI. We have to report suspected child abuse. If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process we may nave to release some of your PHI. We will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to

protect the information they requested. We have to disclose some information to the government agencies which check on us to see that we are obeying the privacy laws.

For Law Enforcement Purposes. We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

For public health activities. We might disclose some of your PHI to agencies which investigate diseases or injuries.

Relating to decedents.

To Prevent a Serious Threat to Health or Safety. If we come to believe that there is a serious threat to your health or safety or that of another person or the public we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and disclosures where you to have an opportunity to object

We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose such as close friends or clergy. We will ask you about who you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law. If it is an emergency - so we cannot ask if you disagree - we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An accounting of disclosures

When we disclose your PHI we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you.

For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records.

You may be able to even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information.

You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice.

If we change this NPP you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated.

You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights which are granted to you by the laws of our state and these may be the same or differed from the rights described above. I will be happy to discuss these situations with you now or as they arise.

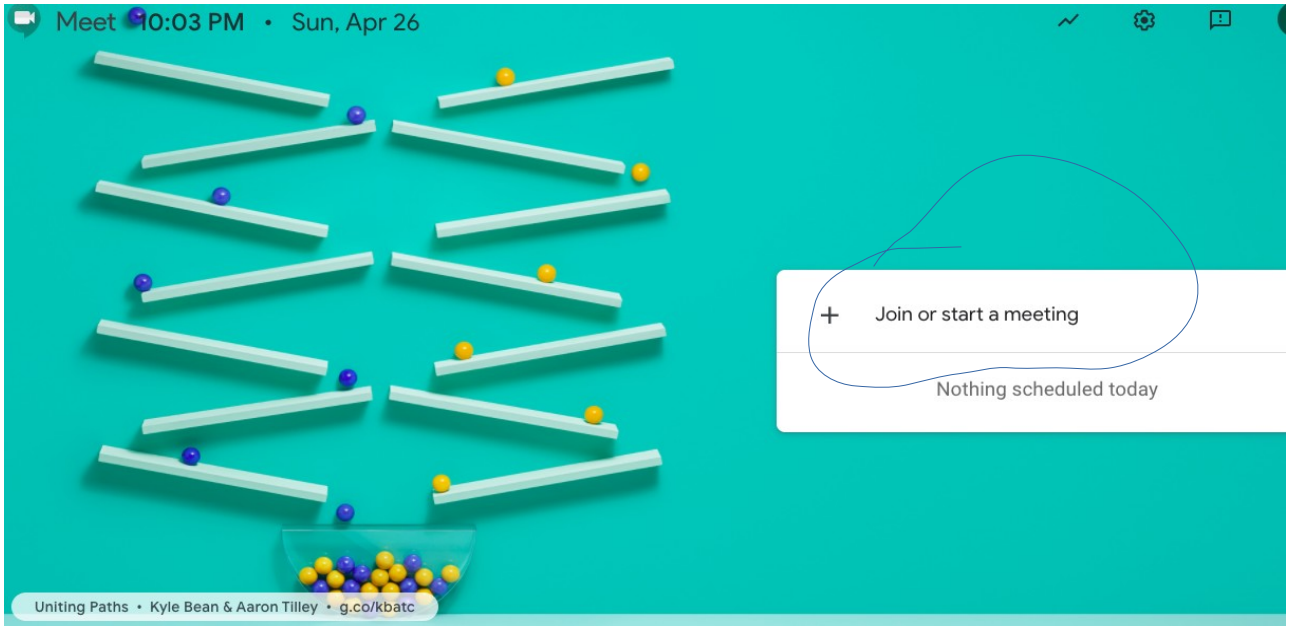
G. If you have questions or problems

If you need more information or have questions about the privacy practices described above please speak to the Privacy Officer whose name and telephone number are listed below. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a complaint with us and with the Secretary of the federal Department of Health and Human Services. We promise that we will not in anyway limit your care here or take any actions against you if you complain. If you have any questions regarding this Notice of our health information privacy policies, please contact our Privacy Officer who is Dr. Brian Thomas and can be reached by phone at 6622318916. The effective date of this notice is March 23, 2006.

Thomas Neuropsychology uses Google Meet for telehealth services whenever possible. If you do not have access to internet services, the telephone can be used in certain circumstances.

To access Google Meet by computer:

1. Your computer must have access to the internet, a microphone and camera. Most laptops and all tablets have a camera and microphone. Open your browser (must be most recent version of browser).
2. Open your browser and go to the website https://meet.google.com/
3. Our office will supply a code for you to enter for your appointment. You will enter the code into the area circled below.



To access Google Meet by smartphone:
1. Download the Google “Hangouts Meet” App via the App Store for Iphone or Goolge Play store for Android phone.

2 Once dowloaded, enter the code provided for your meeting