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

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)