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Disclosure Statement

Welcome to Lux Therapy Center. I look forward to working in partnership with you. This document contains important information about our work together. It summarizes the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regard to use and disclosure of your Protected Health Information (PHI) used for treatment, payment and health care operations.

Educational Background/Accreditation

I have a BA in Psychology and Women's Studies from Rutgers University. I hold a Master's Degree in Mental Health Counseling with an Advanced Certificate towards Licensure as a Professional Counselor in the State of New Jersey. I am also a 200 hour Registered Yoga Teacher, and a Certified Ayurvedic Health Consultant. I take trainings yearly to further my education and maintain my license and certificates.

What can you expect?

I believe in working in a partnership with you. In first session we will get to know each other, you will have time to share your story and your health concerns and goals and I will offer a 1.5 hour consultation where we discuss your history and how to treat your symptoms with the ancient science of Ayurveda. After our initial consultation, you may decide to schedule follow up sessions at your discretion and/or based on my recommendation.

Canceled Appointments

I understand that my clients lead busy lives and sometimes situations arise where you are not able to make our schedule appointment. Your time is set aside for you. I require a 24 hour notice for all cancellations. Cancellations with less than 24 hours notice will be charged the full amount of the session.

Insurance

My desire is to work with clients, not insurance companies. I choose not to be on insurance panels at this time, which leads to more flexibility for myself and for my clients. Most insurance companies require a diagnosis and that I submit information to them about our work together. Insurance companies can also put a limit on the amount of time we can work together. I prefer our consultations to not involve a 3rd party. That being said, I have had people be reimbursed by his/her insurance company. I am happy to provide receipts and a ***mental health diagnosis (I am not***

a licensed medical practitioner) , if applicable. You may submit the receipts for reimbursement.

Agreement
I have read and accept the terms of this agreement and hereby authorize Tierney Farry LLC to consult with colleagues in order to provide information that potentially assists me in achieving my therapeutic goals. Lux Therapy Center and Tierney Farry LLC are authorized to release relevant information as necessary to my insurance carrier.

I understand that when I sign this document, it will represent an agreement between Lux Therapy Center/Tierney Farry LLC., and I.

Client signature ________________________________ Date __________________________

Parent/guardian signature ____
(if minor is under 16 years of age)

Ayurveda Wellness Session Acknowledgment and Agreement

______ **(initial here)** I understand and agree that this wellness consultation will be based on the principles of an Ayurveda program, an alternative approach to health, and that this consultation and any information I may gain are different from and are NOT a substitute for modern medical evaluation and treatment or for preventive testing (such as blood tests, Pap smears, colon screening, mammograms, and any other appropriate screening tests)

I understand that Ayurveda uses a unique system of evaluation and health based on the concept of balance, three doshas and overall tissue health. I understand that the consultant's purpose will be to assess the level of balance in the physiology and to make recommendations based on an Ayurveda health approach to help enliven the inner intelligence of the body and restore balance to the system.

______ **(initial here)** I understand that this consultation and recommendations I will receive are not for the purpose of diagnosing or treating any disease that I may have.

______ **(initial here)** I further understand that it is not within the scope of this consultation for the educator with whom I consult to assume responsibility for the

treatment of specific health problems. I understand that what I will be receiving will be advice as to holistic diet and lifestyle choices.

I understand that the pulse evaluation is for the purpose of assessing overall balance and is NOT for diagnosing the presence or absence of any particular disease.

______ **(initial here)** I agree to consult with my family physician regarding all matters pertaining to any prescription medication or modern medical treatment that I may be taking.

I understand that Ayurveda programs have been developed in part by Ayurvedic scholars associated with universities or other institutions. However, I recognize and agree that any advice or recommendations to me are the sole responsibility of the educator and no other person or organization.

I recognize that no claims or guarantees have been made to me regarding specific medical benefits or improvements in any medical condition[s] I may have.

Signature: ______________________Date: ________________

Parent/guardian signature ____
(if minor is under 16 years of age)

Notice of Privacy Practice

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

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practice, legal obligations and your rights concerning your health information: Protected Health Information (PHI). I must follow the privacy practices that are described in this Notice, which may be amended from time to time.

This is not intended to be a substitute for specific statutory language and legal advice regarding your rights and our responsibilities. If you have a specific legal question, please seek legal advice from a qualified attorney.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy.

Routine operations for **Tierney Farry LLC** would not require me to secure authorization before sharing your information. Routine is defined as any services that do not have to do with treatment, i.e administrative functions, and quality assurance functions. Any information which is shared is done so by disclosing only that information which is "minimally necessary" in order to perform the operation that is necessary. The examples provided in each category below are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. **Treatment:** I may use PHI to provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment.
2. **Payment:** I may use or disclose PHI to secure payment for services which I have provided.
3. **Court Orders:** I may use and disclose PHI in response to a court or administrative order. I will share information in response to a subpoena. I will seek your authorization to share information requests in regards to discovery proceedings, or other lawful requests.
4. **Required or Permitted by Law:** I may use or disclose PHI when I am required or permitted to do so by federal, state, and local law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health and safety or the health and safety of others. I will also share PHI with authorities that monitor compliance with privacy practices.

When information is shared outside of "routine operations" I will seek your authorization in writing

B. Uses and Disclosures Requiring Your Written Authorization

I am bound by professional ethics to protect client rights to confidential communications in regards to their involvement in counseling. For this reason, if information about your participation in therapy is to be released to anyone, I will require a signed "Release of Information" from you for any of the following:

1. **Psychotherapy Notes:** Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.
2. **Marketing Communications:** I will not use your health information for marketing communications without your written authorization.
3. **Other Uses and Disclosures:** Uses and disclosures other than those described in Section I A above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to a school, or your attorney. You may revoke any such authorization at any time.

II. <u>YOUR INDIVIDUAL RIGHTS</u>

A. **Right to Inspect and Copy.** You may request access to your PHI maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records if I believe the information may be harmful to you or

someone else. You have the right to appeal any denials. I may charge a fee for the costs of copying and sending you any records requested.

B. **Right to Alternative Communications.** You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations. For example, you can request that I only contact you at work or by mail. To make a request it must be made in writing.

C. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. You can request a list of disclosures going back for up to six years but not earlier than April 14, 2003. There will be no charge for one list per 12 month period. There may be a charge for more than one list per year.

D. **Right to request Amendment.** You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request if it is determined that the PHI is 1) correct and complete 2) was not created by **Tierney Farry LLC** and is not part of our records, or 3) is a type of information that I cannot disclose. If I deny the request for changes, I will tell you in writing the reasons for denial and explain rights to have your request and our denial, together with any statement of disagreement made part of your PHI. If we approve the request, we will change the PHI, and tell you and others that need to know, about the change.

E. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to your clinician at any time.

F. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the **Privacy Officer**. I am an independent practitioner and am therefore the Privacy Officer for my clinical practice. You may also file written complaints with the Secretary of the U.S Department of Health and Human Services Office of Civil Rights, Phone : 202-619-0257 within 180 days of when you knew (or should have known) of some violation act or omission. I will not retaliate against you if you file a complaint with the Department of Health and Human Services or myself.

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Client signature **Date**

Parent/guardian signature ______________________________________
(if minor is under 16 years of age)