Lux Therapy Center
Tierney Farry LLC
70 Park St. Ste 104, Montclair, NJ 07042
Ph: 973-544-8565 / 973-233-1000 F: 973-233-1004
Email: Tierney@luxtherapycenter.com

Client Registration Form

Date: ________________

Client's last name: ____________________ First name: _____________________ MI _____

Birth date: _____/______/_______ Age: ______ Sex: ______ Marital Status: ______________

Street Address: ____

City: _______________________ State: ______________ Zip code: _______________

Social Security No. :__________-_______-_________

Cell or home phone no: ______________________ May I leave a message? ______Y_____N

Occupation: ________________________ Employer: ___________________________

Email: ____ Referred By:____________________

If you found me on-line please check how:

___Google Search ____Lux Therapy Center website

____IAYT Website ____DaoCloud ____Psychology Today _________________________Other

Household Information: Please list the current members of your household, **not including yourself**

Name	Age	Relationship	Occupation/ School Grade

Must be completed by Parent/Guardian if Client is under 16 years old

Mother's last name: ___________________ First name: ____________________Custody: ____Y ____N

Telephone number: ___________________ Child's Status ___Biological ___Adopted ___Stepchild ___Foster ___Other_________________

Father's last name: ____________________ First name: ____________________Custody: ____Y ____N

Telephone number: ___________________ Child's Status ___Biological ___Adopted ___Stepchild ___Foster ___Other_________________

Please list any other legal guardians:

Name: ___________________________ Telephone number: __________________________

Billing Information

Kindly take the time to read each statement and initial that you acknowledge and agree.

Payment: All payments must be made at the time of service. We accept cash, check, Visa, or MasterCard.	
Non-Payment: Any balance accrued must be paid within 7 days, otherwise services may be suspended.	
Missed Appointments: Because your appointment time has been reserved specifically for you, a minimum of 24 hours notice is required for re-scheduling or cancelling an appointment. If 24 hour notice is not given, please be aware you will be charged for a full session. We understand that on occasion, issues may arise causing you to miss your appointment without the ability to notify the office prior to your appointment; should this arise, please contact us as soon as possible so we may come to an agreement for the session missed.	
Returned Check Fee: Our office charges a $30 fee for any check returned for any reason.	

Person responsible for payment: _________________________________ Relationship to Client:_________

Signature: ____

Telephone number: __________________________________

Fee: $________________

Please Read Carefully

To avoid a conflict of interest, Tierney Farry LLC, who treats minors or adults involved in custody or visitation actions, may not perform any type of evaluations, forensic or otherwise, concerning custody, residence or visitation of the minor.

In addition, Tierney Farry LLC may not participate in any way with regard to any legal actions that her client(s), individuals, couples, and/or families may be involved in.

To participate in such action would undermine and/or damage her therapeutic efforts.

I (we) have read and understand the terms of the document.

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

Signature: ____ Date: ______________________

Witness: ____ Date: ______________________

Notice for communication via SMS messaging, email, & social media

Please be aware of confidentiality and other issues that arise via electronic communication. Initial next to each of the following:

_______ The context of the therapeutic relationship is different from those you may have with other service providers. I understand that I cannot "connect" with my therapist on his/her personal accounts. I understand that this is not only to maintain the appropriate professional relationship boundaries, which are necessary for effective therapy, but also to protect me. Therefore to eliminate the possibility of an unintended disclosure of a therapeutic relationship, I understand my therapist cannot accept social media invitations from active clients on his/her private accounts. I understand I can, however, connect with @LuxTherapyCenter's social media pages.

_______I understand that SMS messages and e-mail messages may not be secure and are not encrypted. Therefore I understand my therapist can NOT guarantee the confidentiality and security of any information I send to him or that she sends to me via e-mail or SMS. I understand that for this reason my therapist has advised me not to send sensitive information via email or SMS message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information.

_______I hereby give permission for my therapist to reply to my messages via e-mail, including any information that he deems appropriate, that would otherwise be considered confidential. I agree that Tierney Farry LLC shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet.

_______I understand that my therapist will limit SMS messages to brief inquiries or responses regarding scheduling.

_______I understand that my therapist may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail.

_______I understand that e-mail and SMS communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or SMS to make or request scheduling changes it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. If I believe I need a response within 48 hours, I will not use e-mail but will call my therapist. If I do not receive an answer to a routine e-mail or text message within two working days, I understand that I should call my therapist.

_______I understand that all e-mail and SMS communications may be made part of my permanent medical record and would be accessible to anyone given access to those records. I also understand that I may withdraw permission for my therapist to communicate with me via e-mail or SMS by notifying my therapist in writing.

Client signature ____

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

Date _________________________________

Acknowledgement

I (we) request that Tierney Farry LLC provide counseling services to me (us). I (we) understand that I (we) am free to refuse this service, and that no guarantee has been made to me (us) as to the results I (we) will obtain from this service. I (we) accept responsibility for all charges for services rendered by Tierney Farry LLC. I (we) agree to the 24-hour cancellation policy, and I (we) understand that I (we) will be charged by Established Fee for appointments not cancelled at least 24 hours in advance.

Client Name ____________________________________ Date _____________________

Signature _______________________________________

Client Name ____________________________________ Date _____________________

Signature _______________________________________

Client Name ____________________________________ Date _____________________

Signature _______________________________________

Client Name ____________________________________ Date _____________________

Signature _______________________________________

Client Name ____________________________________ Date _____________________

Signature _______________________________________

Client Name ____________________________________ Date _____________________

Signature _______________________________________

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. <u>USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)</u>

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. YOUR INDIVIDUAL RIGHTS

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.

Client signature ____

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

Date __________________________________