Lyn Milum

Eden Energy Medicine Advanced Practitioner
EEM-AP, LMT FL# MA 57728
Altamonte Professional Center, 452 Osceola Street
Suite 109, Altamonte Springs, FL 32701
407-310-2732

INFORMED CONSENT

Welcome to my practice. Thank you for choosing me as a member of your wellness care team. Before we get started, I would like to give you sufficient information about me and my practice to feel comfortable entering into a working relationship. Please read and sign this statement and let me know if you have any questions or concerns.

*As an **Energy Medicine Practitioner**, I assess and address the subtle body energies of the Aura, Chakras, Meridians, Triple Warmer, Celtic Weave, Five Rhythms, Bio-Electrical System, Strange Flows, and Fundamental Energy Organizations including Grounding and Cross-Lateral Patterning. I invite gentle re-connections using body energy access points, employ Meridian Tapping Techniques, and engage the energies of the biofield. Energy Medicine complements all other traditional medical and holistic approaches, and stands alone as a complete system of self-care. Energy Medicine can bring balance to the energetic patterns of physical illness and emotional or mental distress, and can also promote high-level wellness, prevention of disorders, and peak performance. When energy patterns are restored, healing follows. As an Energy Medicine Practitioner, I do not offer diagnosis, treatment or cure for any physical, mental or emotional health care problem, disorder or illness, nor do I make recommendations involving pharmaceutical drugs or surgery, or handle medical emergencies.*

*As a **Licensed Massage Therapist**, I am trained in the use of safe and gentle hands-on techniques to invite your energies to return to balance. I use muscle response testing (Energy Kinesiology) to assess subtle energy states. Clients remain fully clothed, and I recommend you wear comfortable, non-constrictive clothing to your sessions. I offer a minimal amount of massage therapy, focusing primarily on subtle energy balancing through light touch and education.*

***What to Expect:** You are entirely unique, so the pace of your progress towards your goals will also be unique. Since the experience of wellness in body, mind and spirit has direct correlations in the subtle energy fields, addressing subtle energies enables healing. Essentially, your wellness is an inside job, and I make no claims about what your individual outcomes will be along the way. I act as an ally on your healing journey and help you discover the next steps in your process.*

***You are in complete control** of the pace of your progress. I will teach you energy balancing techniques that you can use every day to enhance and extend the benefits of our session work.*

***Session Cost:** $100 per hour. Recommended session time is 1.5 hours = $135, or two hours = $170 Cash, Check, and credit cards are accepted. Outcalls available with travel fee. Fees are subject to change.*

FINANCIAL AND LATE POLICIES

1. *Payment for services is due at the time services are rendered unless other arrangements have made.*
2. *Please give 24 hours notice to cancel appointments when necessary, to avoid being charged for the appointment.*
3. *Please be on time. If you are late, your session may be shorter in order for me to honor other clients. You will still be responsible for the full time you have scheduled.*
4. *Returned check fees are the financial responsibility of the client.*
5. *Please understand that your insurance is an agreement between the insurance company and you. If you choose to seek reimbursement, it is your responsibility to know what is required by your insurance company to do so, including the necessity of referrals for massage therapies. Please be aware of what is offered and covered by your insurance plan.*
6. *We are not participating providers in Medicare, Medicaid or any other government sponsored programs or insurance plans.*
7. *You are responsible for all services provided at the time of treatment and take full responsibility for all bills incurred for treatment.*

HIPAA and NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) was established by the US government to establish rules concerning the use and protections of medical and health information. The rules are intended to provide standard privacy protections for your medical information. We regard the privacy of our patients as a central part of our mission to serve the needs of the patient first. Private controlled use of your information by staff is essential to your care. The Notice of Privacy Practices provides you with information explaining how we use your medical information. I acknowledge that I have been offered a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability. I understand that this acknowledgement means only that I have received the notice and in no way affects the care I receive.

Initials: _____

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PATIENT RESPONSIBILITY

I realize that I am primarily responsible for determining making choices in my healthcare. I understand that when energy congestion is freed there can be accompanying shaking, transitory physical discomfort, and emotional releases. I have been advised that most sessions result in a client's feeling more relaxed and centered; occasionally the changes initiated in a session will require extra attention to help me integrate the work, and it is my responsibility to communicate any uncomfortable reactions to my practitioner. I have the right to refuse any procedure and will notify my practitioner IMMEDIATELY if I have any concerns during an energy session. I am aware that any verbal discussions are meant only to suggest options. If at any time I feel I have concerns regarding my mental well-being, it is my responsibility to seek appropriate treatment from a qualified mental health care provider. I will notify Lyn Milum of any changes regarding my health status that may impact my plan of care. ***If Lyn Milum recommends that I be assessed by a medical professional, and if I choose not to, I understand that scheduling our energy sessions may be delayed until I do so.***

Initials: _____

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LIMITS OF PRACTICE

I understand that Lyn Milum does not diagnose or treat physical, emotional or mental illness. I understand that Lyn Milum assesses and addresses the subtle body energies that pattern the physical, emotional and mental well-being. I acknowledge and confirm that my treatment was explained prior to the service being performed. I understand and consent to body energy system assessment and subtle energy balancing which may include a wide variety of Energy Medicine, Massage Therapy and Meridian Tapping Techniques. I understand and acknowledge the medically acceptable alternatives and risks associated with the proposed treatment.

I understand that most people report significant progress towards their goals from working with an Eden Energy Medicine Practitioner, however there are no guarantees of outcomes. Each party agrees to hold harmless the other party and its agents, officers, and employees from and against any and all liability, expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever including but not limited to, bodily injury, death, personal injury, financial or business losses, or property damage arising from this voluntary relationship.

Initials: _____

The above information is accurate and true to the best of my knowledge. I understand that Energy Medicine Practitioners do not diagnose or treat disease, prescribe medications or manipulate bones. I further understand that Energy Medicine is not a substitute for psychological treatment, or medical attention or examination. I agree to I take responsibility for alerting my practitioner to any physical, mental or emotional changes or discomforts that may occur during the session. I understand that rebalancing Subtle Energies often brings changes for 24 to 48 hours after the session; these can feel like emotional releases or sensitivity, and variations in physical sensations. I understand it is recommended that I take it easy for at least a few hours after my sessions to allow for smoother integration. I agree to contact Lyn if I have concerns about my experience of integration after my sessions.

I HAVE READ AND CONSENT TO ALL THE POLICIES AND INFORMATION STATED ABOVE.

Print Name: _____ Sign Name: _____ Date: _____

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NEW CLIENT INFORMATION Date : _____/_____/_____

Name: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

if not in Florida, – circle Time zone: EST, MST, CST, PST

Are confidential messages OK? ___Y ___N

Only provide contact numbers you would like me to use. Please update me on changes to your contact information. Check next to your preferred contact number.

Home#: _____ Cell#: _____

Work#: _____ E-mail: _____

Age: _____ DOB: _____/_____/_____ Gender: _____

Emergency Contact Name:_____ Relationship: _____Phone:_____

Emergency Contact Name: _____ Relationship: _____Phone:_____

How did you find me? _____

Referred, by? _____

May I thank the person/agency for the referral? ___Y ___N

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Significant stress incidents*: Please note accidents, injuries, surgeries, and traumas, and the year they occurred. Add more details to the back of this page, if you wish.*

*event:*_____ *year:*_____ *event:*_____ *year:*_____

*event:*_____ *year:*_____ *event:*_____ *year:*_____

*event:*_____ *year:*_____ *event:*_____ *year:*_____

My primary goals in my life and health are now:

_____

_____

_____

Release of Records

Provided I am informed it is necessary, I consent to the release of confidential information relating to me or my child, if the release of that information: a) follows a statutory requirement, a Court Order or a legal duty; b) is to a professional psychologist, a clinician or a medical practitioner as part of a referral process initiated by either me or Lyn Milum; c) is for the purposes of discussing my treatment history, or that of my child, with my medical practitioner or any former clinician or psychologist who has provided services to me or my child, d) may, in the opinion of Lyn Milum, prevent the commission of a serious crime and/or harm to a third part and/or harm to me or my child; or e) is reasonably required by Lyn Milum. I also authorize Lyn Milum, LMT or her representatives to release any grantor or insurance company any information required to secure payment for charges incurred by me or on my behalf if applicable. I agree that I am responsible for my actions and by signing this, agree to these terms. I give permission to Lyn Milum to share stories of my healing journey without using my name. By completing and signing this form, I affirm that I have provided accurate information.

CLIENT SIGNATURE _____ DATE _____

PRINTED NAME _____

HIPAA – Notice of Privacy Practices
Privacy Policies Notice

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard the information included in your files. We have installed a firewall on our computer; computerized files can only be accessed with a password; and all paperwork is kept in a locked filing cabinet.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.

Your Personal and Protected Health Information

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

* We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
* We may disclose your PHI to any third party you designate in writing.
* We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
* We may disclose your PHI if we ever sell or transfer our practice.
* We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
* We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
* We may disclose your PHI to a health oversight agency for activities authorized by law.
* We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
* We may release your PHI as necessary to comply with laws relating to Workersí Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
* We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
* Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
* We may use or disclose your PHI when required by law.
* We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to our Privacy Officer at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

Original Effective Date: April 14, 2003

This notice remains in effect until it is replaced or amended by changes in the law.