

Dug Y. Lee, MA, LMHC
elements therapy LLC
3400 Harbor Ave SW #428
Seattle, WA 98126
206-407-9908

GREETINGS! Thank you for making an initial appointment with me. Below are the directions to my office. Each appointment is 50 minutes long and the fee or co-pay is payable via cash, check, or PayPal. If you are using insurance, please check with your insurance company to find out what your co-pay is and bring with you a copy of 1) the front and back of your insurance card and 2) your driver's license.

If you need to make a change in the appointment time, please call me at least 24 hours in advance.

Following is the paperwork I mentioned to you. Please fill out and/or sign pages 8-11 and bring those with you to your session (for couples: each person should fill out their own paperwork).

I look forward to meeting you!

Dug

A handwritten signature in black ink, appearing to read 'Dug Y. Lee'. The signature is fluid and cursive, with the first name 'Dug' being more prominent and the last name 'Lee' following in a similar style.

DIRECTIONS:

West Seattle Office: From the West Seattle Bridge heading toward West Seattle, take the Harbor Ave SW exit (not to be confused with Harbor Island). Turn right at the light onto Harbor Ave. On the right you will see a large red and white building—that is the ActivSpace building where my office is located. Park on the street. At the elevator, buzz up for #428. You will not hear me say anything, but I will send the elevator down for you (you will see the elevator button light up). Come up to the 4th floor, turn right, go down to the end of the hall, turn right again, and my office is #428.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapy students, licensing, and conducting or arranging for other business activities. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health

information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donations, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your therapist has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically. You may have the right to have your therapist amend your protected health information. If we deny request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003.

DUG Y. LEE, MA, LMHC
Washington State License No. LH 60125809
elements therapy LLC
PO Box 16691
Seattle, WA 98116

DISCLOSURE OF INFORMATION, POLICIES, AND CLIENT AGREEMENT

PROVISION OF THE FOLLOWING INFORMATION, AND WRITTEN ACKNOWLEDGEMENT OF ITS RECEIPT, ARE REQUIRED BY WASHINGTON STATE LAW. PLEASE READ IT CAREFULLY. I WELCOME THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR MY SERVICES.

Counselors practicing counseling for a fee must be registered or certified with the Department of Licensing for the protection of public health and safety. Registration of an individual with the Department does not include the recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

Your Rights As a Client in Counseling

As a client in counseling, you have certain rights that are important for you to know. There are also certain limitations to those rights of which you should be aware.

As a client of a counselor registered or licensed by the State of Washington, you have privileged communications under state law. With the exception of the situations listed below, you have the right to have information you share with me held in strict confidence; that information includes the fact that you are seeing me. The privilege is yours, not mine, and cannot be waived without your consent. I will always act to maximize privacy even when you waive your right to confidentiality.

The following situations are exceptions to your right of confidentiality:

1. If I believe you are likely to do harm to yourself or to another person, I am required by law to take steps to protect you and/or the other person.
2. If I believe that you may be physically or sexually abusing or neglecting a minor child or vulnerable adult, or if you report information to me about the possible abuse or neglect of a child, I am required by law to report this to Children's Protective Services or Adult Protective Services, state agencies.
3. If you are currently in litigation, or become involved in litigation during treatment or file a complaint against someone for malpractice, you may be asked to disclose information regarding your therapy as part of that process.
Although I will request your consent to release information, I can be legally obligated by subpoena or court order to turn over my records and testify. Nevertheless, please inform me as soon as you know that you are likely to be in such a legal situation, so I can exercise due caution so as to protect your privacy.
4. If you submit claims to your insurance company, they will likely require some information regarding your treatment with me. Most insurance companies only require basic information, often including a psychiatric diagnosis. You have the right to know

the diagnosis that I use in any communication with your insurance company or third-party payer or agency. All of the diagnoses that I use come from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). A copy of this book is available in my library and you are free to look at it.

Should you attempt to use your health insurance to cover my services, there are a few things you should know. Some insurance companies will partially or fully cover my services and some will not.

If this is a concern for you, please check with your insurance company regarding your eligibility for benefits and with me regarding the policies and procedures I use concerning health insurance or other third party coverage. I need to be very clear that I cannot guarantee that your treatment with me will be covered. Further, you are directly responsible to pay me your co-pay / applicable share of fee when my services are performed. If your insurance company does not compensate me for my services you will then be responsible for the full amount of the session.

5. If you have been referred to me by an Employee Assistance Program (EAP) for evaluation, I may be required to disclose basic information about the evaluation such as a description of the problem, diagnosis, and therapeutic recommendation. I will share with you all information I will be sending to the EAP representative at your request. You are free to get a second opinion, although the financial obligation you incur in obtaining one must be settled between you and your EAP agency.

6. If you are seeing me in couples or family therapy, and you, your partner or another family member should happen to see me in an adjunctive individual session, information shared with me in that meeting may be shared by me in joint or family sessions if I believe it to be in the best interest of the work we are doing together.

Likewise, if you are a group therapy member and you share information with me outside of group, it may be shared by me in subsequent group sessions if I believe it to be in the best interest of the work we are doing together in the group.

Please note that I do not work with couples when either person has current chronic **substance** use (without current treatment), chronic **suicide** attempts, or an ongoing **affair**. All have similar effects on the ability to improve relationship issues and I have found that it is difficult to obtain therapeutic benefits prior to the individual addressing the addiction, suicidality, or affair.

7. If our therapeutic relationship involves more than one person (e.g. spouse, parent, partner) I will not release any information to a third party (court, attorney, etc) without the signed permission of all parties involved in our therapeutic work together, except as required by law. Your signature on this disclosure statement represents agreement to this requirement. If this concerns you, please bring it up the next time we meet together.

8. In some cases it will be useful to the therapy for me to discuss your situation with others such as your physician, former therapist, etc. In such cases, I will seek your written permission for this exchange of information.

9. I regularly consult with colleagues regarding my work with clients to gain feedback and suggestions about directions for my growth. My work with you may be discussed in formal or informal sessions with my colleagues or with other professionals with whom I

seek consultation. During these consultations, neither your last name nor other unique identifying information will be used. All of these discussions with other professionals are subject to the same provisions of confidentiality discussed above.

10. To increase the effectiveness of my work, I regularly use the following adjunctive methods in treatment. I may video or audiotape some or all of our sessions for my personal review, or to use in consultation and supervision as described in the above paragraph. In addition, I may have a colleague join me as a co-therapist for one or more sessions. I will seek in advance your specific permission to use any of these above-mentioned adjunctive methods.

11. If you have been directly referred to me by someone else, I may, as a good business practice, acknowledge to him or her that you have contacted me and thank him or her for the referral. I will not discuss your situation with them unless I have your written permission.

You always have the right to request a change in treatment or refuse therapy. It is important that what we do together meets your needs. If you believe you are not being helped, please tell me so that we can work through the difficulty together. If we are unable to do so, I will assist you in finding another therapist.

My phone number is 206.407.9908. I check my mailbox at regular intervals throughout the day. If you are unable to reach me and are urgently in need to help, call the Seattle Crisis Clinic at 206.461.3222. (If outside of this area, you may need to contact another local area crisis line) or call 911 for immediate help.

Although you are free to terminate therapy at any time, it is my request that you discuss your decision and reasons for termination at the beginning of a regularly scheduled session. I consider it of therapeutic value to you that the counseling relationship be closed in a straightforward manner, ensuring that all counseling issues have been dealt with to the best of your and my ability. In any case, notice of termination will result in my scheduling other clients into your regularly scheduled time slot. If you cancel an appointment or miss an appointment without leaving notice of rescheduling with my voicemail, notice of termination will be assumed and your time slot will be given to the next available client.

Appointment and Fees

Appointments are scheduled at the frequency needed by the client. The sessions are 50 minutes, unless we arrange in advance to meet for longer time. Longer sessions will incur an extra charge based upon the amount of time we take. The scheduled time for your session is set aside for you. If you miss a session without canceling or if you cancel with less than 24-hour notice, you will be billed in full for that time. Cancellations can only be done via phone, not email, unless previously arranged with me.

Insurance or other third-party payer will not compensate you under such circumstances. If you are late for a session, you will be seen for the remainder of your scheduled time and charged the full rate.

Each 50-minute session is \$90. Payment must be made at the conclusion of each session unless we specifically agree on another payment schedule. I accept check or cash, or I can send you a PayPal bill. I cannot take medical coupons or barter. A \$40.00 fee per check will be charged for returned checks. A finance charge of 1.5% per month

or \$2.00 minimum, whichever is greater will be assessed on balances outstanding over 30 days, unless we have made other arrangements in advance about you incurring a debt to me. In any case where a bill is accumulated, we will have a written agreement regarding a payment schedule.

If I am doing work related to your treatment that is outside the bounds of our scheduled counseling, I will bill you on an hourly basis for all the time I spend on your case. This includes travel time to another locations (such as the hospital, your home, an attorney's office, or another setting), meeting with other professionals regarding your case, writing reports, preparation time, etc. My fee for this type of work is \$100.00 per hour.

Following the completion of our work together, your complete and clinical records will be stored and available for review. After three years a clinical summary and full financial record will be maintained for an additional four years. After seven years all records will be deleted from my computer systems, as well as physical files shredded.

My Training and Approach to Therapy

I am currently working toward a PhD in Clinical Psychology through Fielding Graduate University. In 2006, I earned an MA in Psychology from Fielding Graduate University and an MA in Applied Behavioral Sciences from the Leadership Institute of Seattle through Bastyr University (Kenmore, WA). I earned a B.S. in Operations Management from the University of Tennessee (Knoxville, TN).

My therapeutic orientation is derived primarily from Systemic Therapy. I have been exposed to several other theories of therapy, including Narrative, Strategic, Structural, Attachment, Cognitive Behavioral, and Humanistic. I use my own blend of treatment methodologies from these modalities. As a life-long learner I continue to educate myself in newer methods of therapy through workshops and classes offered for therapy professionals.

Each course of treatment is unique to those who participate in it, and thus your therapy will be a blend of what you and I do together. I am responsible for developing and implementing a course of treatment that will most effectively deal with your issues. You are responsible for your decisions and for changing. This means that you must work on your issues both inside and outside of our counseling sessions. People and situations are complex~ I cannot guarantee that specific changes will occur as a result of our counseling together.

We will be taking this journey together. You are responsible for setting the goals and for working toward change outside of the therapy hour as well as during it. My role is to educate and support you during this period of change. In supporting your perception of reality, present and past, I will not attempt to determine in a legal sense whether events you describe happened exactly as you remember them. I see you as the one who sets the course for your own life and as the one responsible for the decisions and life changes that you make. I may, at various times, make suggestions and give advice, but of course, you are in charge of the choices you make and how you implement them.

I ascribe and adhere to the Codes of Ethics of the American Psychological Association; the American Association of Sex Educators, Counselors, and Therapists; and the National Board for Certified Counselors. I must also answer to the ethical and professional standards of the Washington State Omnibus Credentialing Act for Counselors and the Uniform Disciplinary Act for the Regulation of Health Professions.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Pursuant to the Health Insurance Portability and Accountability Act of 1996
(HIPAA) and RCW 70.02.120)

By my signature below, I acknowledge that I received a copy of the Notice of Privacy Practices (see p.1) for Dug Y. Lee and elements: therapy for individuals and couples.

Signature of client (or personal representative)

Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name

Relationship to Client

Date

CONFIDENTIAL CLIENT INFORMATION FORM
Dug Y. Lee, MA, LMHC
PO Box 16691 Seattle, WA 98116 206-407-9908

GENERAL INFORMATION

Name _____ Date of Birth _____

Street Address _____

City and Zip _____

Phone (daytime) _____ Messages OK? Y / N

Phone (evening) _____ Messages OK? Y / N

Email (if email contact is OK) _____

Occupation / Employer _____

Marital / Partnered / Co-habitation Status _____

Partner's Name/Age/Gender _____

Other Members of Household (Name/Age/Gender/Relation/Species) _____

FINANCIAL RESPONSIBILITY

I hereby acknowledge full responsibility for payment of services at time service is rendered.

Signature of Responsible Party _____

HEALTH INFORMATION

Have you seen a mental health professional before? Y / N

Have you been diagnosed with a mental health condition before? Y / N

If so, please explain: _____

What treatment did you undergo? _____

Are you currently taking any medications or supplements for a mental health condition? Y / N

If so, please state name and dosage _____

Do you or have you had any physical ailments? Y / N

If so, please state _____

Do you have (currently or past) suicidal thoughts or urges? Y / N

Do you have (currently or past) thoughts or urges to harm others? Y / N

SUBSTANCE USE INFORMATION

Do you drink alcohol? Y / N How much/how often? _____

Do you use recreational drugs? Y / N What type? _____

How much and how often? _____

CURRENT SITUATION

Why are you seeking counseling? _____

What are your goals for counseling? _____

How did you find out about my services? _____

EMERGENCY CONTACT

Name _____ Phone _____

Relationship _____ I give permission for Dug Y. Lee to contact the above-named person in any situation she deems to be an emergency.

Client Signature _____