Karen K. Lucas M.A., L. M.H.C.LH#11339

Consulting and Counseling - Individuals, Couples, Families and Groups

Disclosure of Information, Policies and Client Agreement

WASHINGTON STATE LAW REQUIRES PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGEMENT OF ITS RECIEPT. PLEASE READ IT CAREFULLY. I WELCOME THE OPPORTUNTIY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR MY SERVICES.

Education

M.A. Applied Behavioral Science
Bastyr University L.I.O.S
Kenmore, Washington
Major: Systems Counseling

Bachelors of Arts
Washington State University
Pullman, Washington
Major: Hotel and Restaurant Administration

Seattle Massage School 1992

Therapeutic Approach

My approach to therapy is systemic and somatic, developed over the course of my career as a Psychotherapist, Craniosacral and massage therapist. Within the systemic approach we are all seen as part of a system that includes our intellect, feelings, and body. My style includes Somatic Transformation therapy that integrates both the body and mind informed by the PolyVagal Theory. I am influenced by the theorist Bowen, Bowlby, Proges , Whitaker and Minuichin, Allan Schore, Esther Perrel, Stan Takins, Susan Johnson, John Gottman, Danie Siegel, and many others. Systemic therapy looks at the impact on our systems from many sources in our lives these patterns stay in our emotional and physical bodies. These patterns are the familiar structures that influence our neurobiology, behaviors and relationships and have both helped us and/or harmed others or ourselves. I intend to create a safe place to explore both the external and internal systems from the past and present, the ones we are born into, and those we create ourselves. With compassionate curiosity and humor we create knowledge, empathy, understanding. We explore these systems and how they are showing up in the present day. By intergrading and updating the emotional, neurological systems and relational roles we can create the lives we want. These are the foundational concepts that support my therapeutic approach.

Confidentiality and Consultation

Everything said during our counseling session is strictly confidential. I will not disclose information about you that could identify you in any way, without your written and signed permission, unless the law binds me to do so. The circumstances in which I am required by law to release information include:

- if it comes to my attention that a minor child or dependent adult is being abused or neglected,
- if you give serious indications that you intend to harm yourself or another person,
- if you confide that you have committed or intend to commit a serious crime,

- if you submit claims to your insurance company they will likely require some information regarding your treatment with me. Most insurance companies require basic information including a psychiatric diagnosis.
- if the court orders me to disclose.

As part of my own professional growth, and to enhance the quality of the services I provide, I regularly meet with other counselors and therapists to monitor my work. During the course of these professional consultations sessions I may discuss your situation, but will do so without disclosing your full name or any other identifying information. This continuing professional education provides a level of quality assurance that assists us both.

Experience

I have been providing counseling to couples, individuals and families and facilitated different groups of parents, and body workers at my private practice in Seattle since 2003. Prior to my private counseling practice I completed a formal one-year internship at a youth and family services organization. My bodywork practice started in 1993. As a licensed massage therapist I have provided education, massage, and CranioSacral therapy for infants, children and adults. I continue to seek education through seminars, consultation groups, membership in professional organizations and training seminars. It is my belief that it is through continuing education I can provide the best professional and ethical services possible to my clients.

Appointment and Fees

Appointments are usually scheduled once per week or once every other week. **The sessions are set at 50 minutes (insurance) and 60 minutes for couples or arrange in advance** to meet for a 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 the 48 hours notice,** I will bill you in full for that time. If you are late for a session you will be seen for the remainder of your scheduled time and charged the full rate. After a missed appointment you must contact me within 48 hours to confirm your next appointment and pay for the missed appointment at $145. If you fail to contact me within 2 days following a missed appointment without cancellation, you may loose your regular appointment slot. **When you cancel more then two of your appointments in a 120-day period you will be charged an administrative fee of $145 and could cause the release of your regular held appointment time.**
______(Initial Here)

My standard fee based on insurance coding is $145.00 per 40-50 minute session 90834, and $175 for 51-60 minute session code 90837. **60 minutes only sessions for couples, I do not bill insurance for couples**. I do have a sliding scale available for payment at the time of service. If you are applying for a fee adjustment due to a financial hardship we will discuss an appropriate fee based on Gross Yearly Household income and number of persons living in household. Upon verification of income an amended fee agreement will be signed and placed in your file. You will also be provided with a copy of this agreement. Payment must be made at the conclusion of every session unless we specifically agree on another method of payment. I accept checks or cash, credit cards with a small processing fee. I cannot take medical coupons or barter. A $30.00 fee per check will be

charged for returned checks. A finance charge of 1 percent per month or $2.00 minimum, which ever is greater, will be assessed on balances outstanding over 30 days, unless we have made other arrangements in advance about your incurring debt to me. In the event this matter is turned over to a third-party for collection, you agree to pay all principal interest and cost of collection. You further agree that the reasonable cost of collection shall be fifty percent (50%) of the total amount of the principal and interest due and owing. **_____(Initial Here)**

Phone Consultation

In the course of many clients' therapy issues arise between sessions, which requires attention prior to the next scheduled session. Should this happen, **please leave a phone message**. I will return your call as soon as possible after receiving your message. Only calls, which exceed 10 min in length, will be charged, at the prorated regular amount. If you need immediate support please call the crisis clinic (206) 461-3222, as VM are temperamental.

Client Grievances and Referrals

If, at any time you have questions, doubts or concerns about the course of treatment or approaches used in therapy, **I encourage you to discuss these with me**. You have the right to choose a counselor who best suits your needs and purposes. Remember that treatment is optional and can be terminated at anytime. If you choose to seek assistance from another counselor or therapist, or if I find I am unable to provide you with services, I will offer you the names and phone numbers of at least two other counselors whom you may contact. It is your right to select and to make arrangements with another counselor if you decide to continue counseling.

If you think I have behaved in an unprofessional or unethical manner, please advise me so that the problem can be clarified and resolved. If you think that this does not resolve the issue, you may contact the State of Washington Department of Licensing Attn: Counseling Division P.O. Box 9012 Olympia, WA. 98504-8001

The State of Washington requires that the following appear on every client's disclosure statement: "Counselors practicing counseling for a fee must be registered or certified with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment."

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.

A federal regulation, known as the "HIPAA Privacy Rule" requires I provide a detailed notice in writing of my privacy practices. Much of what is required has already been covered in my disclosure statement to you. This notice addresses topics not covered there.

In this notice I describe the way we may use or protect private information about you. The HIPAA Privacy Rule requires I protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify you. This information is called 'Protected Health Information" or "PHI." This notice further describes your rights as my patient and my obligations regarding the use and disclosure of PHI.

Although HIPAA allows the free exchange of information between treating professionals, I will not disclose information regarding our work together without a specific release signed by you. The HIPAA Privacy Rule specifically protects Psychotherapy notes from disclosure unless specifically authorized by you, or otherwise required by law. This means I will not discuss your treatment with me with your Doctor or other professional without your written permission. Exceptions to this are outlined above in the section: *Confidentiality and Consultation.*

Right to Receive Confidential Communications: you have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that I contact you at home, rather than at work. Your request must be made in writing, signed and dated. I will accommodate all reasonable requests. You do not need to give a reason for your request; but your request must specify how or where you wish to be contacted.

Right to Receive an Accounting of Disclosures: You may request that I provide you with an accounting of disclosures I have made of your health information since April 14, 2003. An accounting is a list of disclosures. But this list will not include certain disclosures of your health information such as those made for the purpose of treatment, payment and health care operations or disclosures that you authorized in writing. Please submit your request to me in writing. The first list you request in a 12 month period will be free up to 15 pages, but there may be a reasonable charge for a larger file and for subsequent requests.

Requests to amend your Health Information: You may request that I amend any of the health information used to make decisions about your care, including treatment or payment records. To do so you must submit a written request to me, and tell me why you believe the information is incorrect. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. I may also deny your request if you ask me to amend health information that was not created by me, unless the person or entity that created the health information is no longer available to make the amendment; is not part of the health information we maintain to make decisions about your care; is not part of the health information that you would be permitted to inspect or copy; or is accurate and complete.

If I deny your request to amend your health information, I will send you a written notice of the denial stating the reason for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and my denial be attached to all future disclosures of the health information that is the subject of your request. If you

choose to submit a written statement of disagreement, I have the right to prepare a written rebuttal (as well as the original request and denial) to all future disclosures of the health information that is the subject of your request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with me or the Secretary of the United States Department of Health and Human Services. I respect your right to file a complaint with me or with the Secretary of Health and Human Services. If you do so, I will not retaliate or take action against you for filing a complaint.

Office Procedures: I have entered into written agreements with my Business Associates who provide services for me to ensure they protect your privacy also. Some examples of Business Associates are my Attorney and collection agent. Telephone and email messages are accessible through a password known only by me. In addition, my electronic day planner is also password protected and known only by me. Client files are stored in a locked file cabinet for ten years and then are destroyed.

Questions: If you have any questions, want more information, or want to report a problem about the handling of your information please call me at 206-3245-744. To submit a request for restriction of information or record amendments, please send a written statement to my office attention: Karen K. Lucas M.A.-A.B.S 1605 12th Ave. Suite 30, Seattle, WA. 98122. Please note that in accordance with HIPAA, I am not required to agree to a restriction that you request.

I have the right to change my practices regarding the protected health information I maintain. If I make changes, I will update this Notice. You may receive the most recent copy of this Notice by calling and asking me for it or by visiting my office to pick one up. _____**(Initial Here)**

Client(s) Consent to Treatment

I have read or have had satisfactorily explained to me Karen K. Lucas's Disclosure of Information, Policies and client Agreement and understand it. I have asked any questions that I had about this statement and about statements regarding fees and payment policies. I understand and agree to the description of confidentiality and its exceptions as stated above. I consent to counseling under the terms described above with Karen K. Lucas M.A. -A.B.S. My signature below indicates that I have received a copy of this agreement.

________________________/__________	________________________/__________
Client Name Date	Karen K. Lucas. MA ABS Date
________________________/__________	________________________/__________
For Minor client, Parent/Guardian Date	Client Name Date