

# CAROL UMMEL LINDQUIST, PH.D., FACLINP

C L I N I C A L P S Y C H O L O G I S T

THE PSYCHOLOGY CENTER  
380 GLENNEYRE SUITE D  
LAGUNA BEACH, CA 92651

Dear New Client

I am looking forward to meeting with you for your first appointment. I love my work as a psychologist and look forward to helping you with whatever challenges you would like to explore and resolve. Enclosed are directions to the office for your information.

There are some policies and procedures that I may neglect to fully review with you initially because I am most interested in understanding you and your concerns. I felt writing them down would save time and avoid confusion. Please retain this agreement and read it at your leisure and please feel free to discuss any questions or concerns you have about these policies or any other matter at any time. As a potential consumer of psychological services you are entitled to be fully informed. I will gladly discuss any of these with you. Of course, I will bring up with you whatever matters seem to directly affect your particular concerns.

My view of psychotherapy is that you, as a client, are hiring me, as the therapist, to consult with you regarding growth issues or problems that significantly impact your life. Some of my clients view our relationship as coaching them to achieve their goals. One aspect of my practice is executive coaching for healthy people who wish to enhance their performance and communication in their profession or lives.

The goals of therapy and coaching are best set by both client and therapist together, so that our agendas in working together can be clear and most effective. With these goals in mind, a treatment plan will be developed using the latest psychological information available for helping you.

## Disclosure Statements

The following statements are to provide you with information concerning therapy, as well as the legal and ethical issues related to services provided by licensed psychologists in California, and federal rules and regulations concerning you.

**TYPE OF THERAPY:** Many different kinds of psychotherapy are available to the consumer today. Although it is difficult to present a comprehensive statement of my therapy style and theory within the confines of this disclosure statement, I want to share some fundamental ideas that we can discuss later if you wish.

Therapy is essentially a relationship between the client and the therapist. The client may be an individual, a couple or a family. The initial focus of the therapy is on understanding

thoughts, emotions and life situations that concern the client. Therapy then offers the support, skills and directions that facilitate the client's desired changes.

As a client you have the ability to understand and implement change; you are responsible for deciding the ultimate course of action. Through a sequence of self-explorations, which include an investigation of your family history and a commitment to change personal behaviors, you learn more about yourself and the external factors that effect the quality of your life. You may find improved skills in the areas of communication, decision making, personal effectiveness, self-control and self understanding. Formal and informal assessments, readings, structured experiences, journal writing and "homework" are sometimes used to augment the therapy experience. You are in full control of what you want to accomplish in therapy and we decide together what methods to use. It is most helpful, I find, if you are as open and honest as possible about what you choose to share.

If I feel you can best be helped by a therapeutic method different from my own scope of practice I will discuss a referral with you.

I am also enclosing copies of my background and a statement of my therapy orientation. These are available on my website as well. A copy of your rights as a client and the ethical principles of the American Psychological Association are available in my office for you to read. I hope our work together will add significantly to your experience of well being and achieving your goals.

**RISKS AND BENEFITS OF THERAPY AND COACHING:** There are benefits as well as risks related to therapy. The desired benefits are your improved ability to identify problematic areas, evaluate reasonable options and take action in an honest manner. A good therapy or coaching experience also offers opportunities to learn important things about one's self, to acquire helpful life management skills and to integrate both past and present learning toward higher functioning. The risks include the awareness of negative feelings and situations, some of which may not be changed to your satisfaction. Some awareness may cause emotional disability or disruption to your current life. The possible realization that therapy is helpful and desired, but beyond the limits of your financial resources is also a risk.

You may wonder if there are any guarantees in the light of the benefits and risks presented here. In short, while I expect that therapy will be helpful, there is no guarantee that therapy with me will be the best way to reach your desired goals. Because every therapeutic experience is unique, it varies from individual to individual. Therefore it is vital that you feel free to discuss any concerns you have about the course of treatment with me at any time. As a client, you also have the right to seek a second opinion from another clinician.

**RIGHTS OF CLIENTS:** My practice is guided by the Ethical Code of the American Psychological Association. A copy of that code, as well as a statement of Clients Rights, are available in my office for you to read. Sexual intimacy between client and therapist is never appropriate during or following a therapeutic relationship. The State Board of Psychologists in Sacramento investigates reports of such behavior.

**INDEPENDENT PRACTICE:** While I am housed with The Psychology Center and enjoy the benefits and the stimulation of interaction with my very skilled peers, we each practice completely independently and are each separately responsible for our own policies and practices.

## Therapeutic Policies

**TREATMENT SESSIONS:** Therapy sessions are usually held once a week for forty five minutes. Sessions are scheduled on a weekly basis until you and I mutually agree that a different time schedule is appropriate. If we decide EMDR therapy for trauma is an appropriate therapy for you, sessions are scheduled differently. After initial orientation session, EMDR therapy is usually scheduled for double session per week or every other week. Sometimes sessions are separated by non-EMDR session to process changes that that occurring. Goals for therapy are determined within the first few sessions. These are periodically reviewed and refined. Termination occurs when both of us mutually agree that the goals have been satisfactorily addressed or there is some other reason to terminate, such as a required move. You have the right to terminate at any time; I ask that you discuss your concerns with me for at least one session before you leave.

**THERAPY AND PHYSICAL SYMPTOMS:** Physical symptoms are often the result of emotional stress. They can be reduced and even eliminated under certain therapy conditions. It is important, however, that an appropriate medical specialist review your current situation to ascertain the degree to which the symptom has a physical base. A physical exam is therefore required when a physical symptom is a primary concern. If there is a physical problem that affects your therapy, I will work closely with your medical specialist to coordinate treatments and services. It is important for you to let me know if you have a persistent physical discomfort. I will discuss a referral to another specialist with you.

**LIMITATIONS AS A THERAPIST:** Because I have family responsibilities, I do not do hospital work or severe substance abuse cases. If we feel you require these special services, I will refer you to someone I trust who specializes in these areas. I will maintain contact with you and support you during that time.

**MEDICATIONS IN PSYCHOLOGICAL THERAPY:** Depending on symptoms and problems, medications may or may not be appropriate. As a psychologist I am not licensed to prescribe medication. In the event a consideration for possible medications for psychological distress seems necessary, then I will refer you and assist in obtaining a medical evaluation. It is your responsibility to inform me of any and all prescribed medications and changes in medications as they may significantly affect your mental status and therapy. It is also important that you are compliant with the course of treatment as prescribed by your physician. For some conditions however, therapy has been shown to be more effective than medications and I will inform you if I feel medications will affect or enhance your treatment.

**CONFIDENTIALITY:** The information presented in therapy is personal and confidential. Information is also legally protected. The only circumstances when information could be shared without your prior written and verbal permission are when there is a clear intention to do harm to yourself or to someone else, when your insurance company asks for routine information previously authorized and when a court subpoena is valid. I also have a legal and ethical responsibility to notify appropriate social agencies of any suspicion of emotional, physical or sexual abuse or neglect of a child, a dependent disabled adult or an elderly person. Please note that if you instigate a lawsuit, your mental status and all your records may become subject to court scrutiny. Even when I receive previously signed written authorizations from insurance or regarding legal matters, I will contact you to discuss whether I feel releasing all or some of the information is in your best interest. It is my general policy to forward all information to you, for you to release to your Insurance Company as you see fit.

**ORIENTATION AND CONFIDENTIALITY IN COUPLE, AND/OR FAMILY THERAPY:** When I treat you as part of a couple or family group, no information is released to outside parties without the written consent of all parties present. Minor children will also be asked for their consent. When we meet in individual sessions in the context of family therapy, no information is shared with other members of the family unless the individual (even though he/she may be a minor child) shares it himself/herself or indicates a willingness for me to share. My orientation to family and marriage therapy is that children and individuals do better when the family remains intact except in cases of domestic violence or child abuse.

**REQUESTS FOR INFORMATION:** Insurance companies, health maintenance organizations, and preferred provider organizations sometimes require extensive documentation of your diagnosis, treatment plans and progress. While I am happy to comply with such requests, I must charge for my preparation time and routine costs if lengthy reports are required. Fees for report preparation will be billable at \$200 per hour and not included in testimony charges.

Such organizations are not covered by legal protection of privilege or confidentiality and may have no ethical guidelines. It is my policy to contact you directly when I receive written requests even when the request includes written authorizations to release information. I do this so we can discuss exactly what you wish released and how I might accomplish this. You should be aware that by using third party payment, the releases you sign and/or the processing procedures followed might eliminate your legal protections of privilege and confidentiality. I find many of my clients are unaware of the existence of the Medical Information Bureau that has over 750 insurance companies as members. They share with other health, life and mortgage insurers, if you sign a general or specific release.

For these reasons and because of the HIPAA regulations discussed elsewhere, when I am asked by you to release information I mail or give the original and a copy to you with an envelope so that you may forward it as you choose.

**Legal Matters:** Some situations involve legal matters. If your are involved in a legal situation of any kind, you are expected to sign the retainer agreement at the beginning of

therapy. This is for your protection and mine. See retainer agreement under forms if this applies to you.

**RECORDS:** I regularly keep written records of our sessions. These records include date of meeting, who was present, how long we met and brief notes regarding the issues we discussed. I also record quotes and specific details if issues of homicide, suicide, or abuse or neglect or other legal matters are discussed. I document calls to and from other care providers. These records are maintained seven (7) years after age 19 for a minor and seven (7) years for an adult per California guidelines. After that they are retained in either full or summary form for an additional eight (8) years. Fees for report preparation will be billable at \$200 per hour and not included in testimony charges.

**CONSULTATION WITH PEERS:** I routinely consult with my therapist peers regarding cases. This is to insure my objectivity and that I do not overlook possible avenues to help you. I do not use my clients' names and try to omit all identifying information. Confidential records of these contacts are kept with your records and I inform you of the discussion if I feel it is helpful to you. If you have any questions or discomfort about this, please do not hesitate to discuss this with me.

**VOICE MAIL SERVICE:** We have a Voice Messaging Service on the 949-494-5432 telephone. If you do not receive a call back within 12 hours of when you leave a message, please call again because I may not have gotten the message. If your call is urgent or is about an appointment in the next 24 hours, please leave a message then press the # then number 4, listen for menu then press # and I will be paged. If it is a life threatening emergency and I can't be reached, call your local hospital emergency room.

**VACATION POLICY:** I will always inform you about my plans to be away from the office on the day(s) we usually meet. When I am not available at times other than our scheduled times, I will usually inform you in advance. In any case, my office will be available to inform you who will be on call. Your signature on this form provides me with permission to share some information about your case with the on-call therapist covering for me. For each vacation, I will inform you what information, if any, I feel it necessary to share and with whom.

**TELEPHONE CALLS AND E-MAILS BETWEEN SESSIONS:** Routine calls for the purpose of scheduling or billing information are an expected part of my service and not billed. Telephone calls or emails that are primarily therapeutic in nature occur frequently and/or require more than ten minutes will be prorated and billed at the usual rate. I schedule telephone for some clients if it is appropriate to their goals and treatment or coaching. Sometimes we have telephone appointments when a client is out of town. I am happy to respond to emails between sessions as well and my email address is on my business card. I encourage you to leave an email with me so that, if as I sometimes do, I see an article or item of interest to you or I think of something useful I will pass it along. I cannot guarantee a timely response on emails so schedule changes and cancellations should be handled by phone. Of course, email correspondence and cellular phone calls cannot be considered secure.

**FEES FOR SERVICES:** The fee for service is \$200 for a 45 minute/hour session. It is best to pay at the desk when you arrive for your session as we may discuss challenging material and you may be more comfortable leaving directly when the session is over. Payment can be made with cash, VISA/MC or a personal check. If you have insurance coverage, we will be glad to provide you with a receipt or statement satisfactory for filing your insurance claim at the end of each month. My office will be glad to assist you in determining the extent and limitations of your coverage. Therapy is a significant personal and financial commitment. Please do not hesitate to discuss financial matters with me.

**MISSED APPOINTMENTS AND CANCELLATIONS:** Sometimes emergencies come up. If I need to cancel or change an appointment time, I will give you 24 hours notice, as I know you will have reserved the time for the appointment. If for any reason I cannot give you 24 hours notice, I will provide our next hour free of charge to you. Likewise, I expect that you will give me 24 hours notice if you must cancel the appointment. If, for any reason, you cannot let me know 24 hours in advance you will be charged the regular fee for the time reserved.

\* \* \* \* \*

**SIGNATURES:** By signing below, you agree as follows:

- I have read the materials presented in this disclosure statement.*
- My signature indicates that I understand the information, and agree with the conditions of therapy that are either stated or implied here, and I commit myself to compliance with them.*
- I understand that once therapy begins, I retain the right to withdraw consent to participate in therapy at any time that seems appropriate.*
- I will make every effort to discuss my concerns about the progress of therapy with you before I terminate.*

\_\_\_\_\_  
Client's Signature Date

\_\_\_\_\_  
Client's Signature Date

\_\_\_\_\_  
Carol Ummel Lindquist, Ph.D. ABPP Date

## NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

My patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by me prior to being filed in the medical records. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information. My practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

### **The following circumstances may require us to use or disclose your health information:**

**To provide treatment:** We will use your health information within my office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between doctors, and business office staff. In addition, we may share your health information with referring physicians, specialists, clinical laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorized health care providers treating patients even when the provider requesting the results did not originally order the tests.

**To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in my office. We may do this with insurance forms sent to you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.

**To conduct health care operations:** Your health information may be used during performance evaluations of my staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

**Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact me to make an appointment. These communications may include postcards, letters, and telephone reminders. I may share your health information with those you tell us will be helping you with any auxiliary treatments, medications, or payment. You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.

**Required by law:** We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Workers' Compensation and similar programs.

### **You are entitled to receive a copy of the Notice of Privacy Practices**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations and laboratory testing.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(parent/guardian if patient is a minor)

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THE PSYCHOLOGY CENTER  
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LAGUNA BEACH, CA 92651

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES**

As of April 14, 2003, medical and mental health practitioners are required by law to provide their patients with a Notice of Privacy Practices, reflecting new federal regulations relating to Personal Health Information (PHI). You do not have to read this Notice, you only need to acknowledge that it was given to you. Even before these new federal laws went into effect, I can assure you that I and other psychologists have been dedicated to protecting the privacy of their clients and the confidentiality of psychotherapy information and records.

**I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES PROVIDED BY THIS OFFICE.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



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**Current Symptoms/Problem and Background Information**

Briefly describe reason for seeking help: \_\_\_\_\_

Approximate date these problems/symptoms first appeared: \_\_\_\_\_

Have you ever had these problems/symptoms before? Yes No If Yes, when? \_\_\_\_\_

Approximate date of last physical examination/visit to your (name of) M.D.? \_\_\_\_\_

For what reason(s)? \_\_\_\_\_

List current health problems: \_\_\_\_\_

List names and telephone numbers of Physicians concurrently treating you and indicate if we may contact them should the need arise: \_\_\_\_\_

List the members of your family and all others living with you at this time:

| Name  | Age   | Relationship | Occupation |
|-------|-------|--------------|------------|
| _____ | _____ | _____        | _____      |
| _____ | _____ | _____        | _____      |
| _____ | _____ | _____        | _____      |
| _____ | _____ | _____        | _____      |
| _____ | _____ | _____        | _____      |
| _____ | _____ | _____        | _____      |

Prior History of Psychological/Psychiatric Treatment or Treatment for Alcohol or Drug Problems

Dates                      Problem                      Outpt/Inpt                      Name of MD/Therapist (Phone if known)

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If you drink alcoholic beverages, please indicate which kind and how often:

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If you use drugs of any kind, including prescription medications and/or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

Drugs (marijuana, cocaine, ecstasy, prescription)                      Purpose                      Dosage/Frequency

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Have you seen a Chiropractor, Physical Therapist, or Alternative Healer? \_\_\_\_\_

Name & how recently \_\_\_\_\_

Names and relationship to you of family members in which there has been a drinking or drug problem (include grandparents, aunts or uncles):

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Have you or has anyone in your family had an eating problem (e.g. overeating, anorexia, bulimia)?

Yes No If yes, who? \_\_\_\_\_

Have you been a victim of physical, sexual or emotional abuse or neglect? Yes No

If yes, by whom?

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Do you currently have any legal problems? Yes No If yes, please describe:

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**Symptom Checklist**

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Please circle any of the following problems that apply to you: Number the most important.

- |                   |                      |                  |                |
|-------------------|----------------------|------------------|----------------|
| Nervousness       | Depression           | Fears            | Shyness        |
| Sexual Problems   | Suicidal Thoughts    | Separation       | Divorce        |
| Finances          | Drug Use             | Alcohol Use      | Friends        |
| Anger             | Self Control         | Unhappiness      | Sleep          |
| Stress            | Work                 | Relaxation       | Headaches      |
| Tiredness         | Legal Matters        | Memory           | Ambition       |
| Energy            | Insomnia             | Making Decisions | Loneliness     |
| Concentration     | Health Problems      | School           | Career Choices |
| Marriage Problems | Temper               | Nightmares       | Appetite       |
| Stomach Trouble   | Bowel Troubles       | Being a Parent   | My thoughts    |
| Children          | Inferiority Feelings | My parents       | Education      |
| Self Confidence   | Anxiety              | Aging            | Guilt          |

Menopause Issues

List parents, step-parents, siblings and any children of yours and/or your spouse who do not live with you:

| Name  | Age | Relationship | Occupation |
|-------|-----|--------------|------------|
| _____ |     |              |            |
| _____ |     |              |            |
| _____ |     |              |            |
| _____ |     |              |            |
| _____ |     |              |            |
| _____ |     |              |            |
| _____ |     |              |            |
| _____ |     |              |            |

Thank you for your time and attention in completing this information form.

Rev. 4/00

**(Optional) Insurance Information (if you wish us to inquire about benefits)**

Name of Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Plan #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

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LAGUNA BEACH, CA 92651

**Retainer Agreement for Professional Appearances  
(Court/Deposition/Hearing/Mediation)**

Expert witness fees for an appearance are \$ 1,500 per half day or \$ 2,500 for the full day. This will not be prorated. When placed on call for testimony a minimum \$ 2,000 retainer for that purpose must be received 10 days prior to being on call in the form of a cashier's check or money order. The retainer covers minimum preparation time and half day court costs. A minimum \$ 800 fee for preparation\* for that day will be charged if the case is settled and Dr. Lindquist's services will not be needed in court. The remaining funds will be returned, less any fees outstanding for reports requested and generated.

I understand that a half court day appearance will cost \$ 1,500 and a full day \$ 2,500 and this will not be prorated. I understand that a half-day is morning to the lunch hour or from the time court comes to order in the afternoon until closing.

I, \_\_\_\_\_, request that Carol Ummel Lindquist, Ph.D. appear at court/deposition/Hearing on the following date/s \_\_\_\_\_ for \_\_\_\_\_ (half or full) day. I have read, understand, and agree to the above.

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Expert Witness' signature

\_\_\_\_\_  
Date

\* Preparation time will be billed at the hourly rate of \$250/hour. A minimum preparation time of 2 hours will be billed for each court appearance. Fees for report and records preparation are be billed at \$200 per hour and not included in testimony charges.

Carol Ummel Lindquist, Ph.D., FAClinP  
C L I N I C A L P S Y C H O L O G I S T

THE PSYCHOLOGY CENTER  
380 GLENNEYRE, SUITE D  
LAGUNA BEACH, CA 92651-2303

**Permission to Release Confidential  
Records to/From Outside Sources**

To: \_\_\_\_\_  
(The person who has information)

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Re: \_\_\_\_\_  
(Yourself and/or your child)

Date of Birth: \_\_\_\_\_

Permission is hereby granted to Carol Ummel Lindquist to obtain/release and  
information about the above named person to/from the above named person/agency  
regarding

\_\_\_\_\_  
(self or child)

Limitations: \_\_\_\_\_

\_\_\_\_\_  
(Things you don't want me to discuss)

Signed: \_\_\_\_\_

Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I routinely gather information from other professionals who have worked with you unless you would prefer I did not. If you have some one you have previously seen in therapy, or another professional such as an M.D. that you would like me to communicate with or get records from, please sign and return to my office. If you want me to talk to them before our first session you may fax this release to me at the above number. Otherwise, bring this form with you and we will discuss whether there is anyone additional it would be helpful to contact. You may make extra copies of this form or get them from me.

Revised 4/00.

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**From 405 or 5 Freeways:** Take 133 South (Laguna Freeway). Go south on Laguna Canyon to Laguna Beach. Turn left on Forest. Follow Forest past ocean around the curve, turning to the right at stop sign. You will be on the main shopping street in Laguna. At Glenneyre the second stop, turn left. My office, 380 Glenneyre, Suite D is between Mermaid and Park streets on your left. Make a left turn through breezeway into the parking lot 380 building.

**From Pacific Coast Highway:** Go north on Forest Ave away from the ocean. (That will be a right turn on Forest coming from the south and a left turn coming on PCH from Newport). Then turn right on Glenneyre. Make a left turn into 380 building.

**Parking:** Find the three parking spaces labeled "the Center." You may park in any open "Center" space. If full, there is metered parking on the adjacent streets. There is metered a metered parking lot next door across Mermaid on Glenneyre and another 2 story lot one block past the office on Glenneyre on the right as you go up the hill.

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## MAP

