***Jack Litman, Ph.D.***

7600 NE 41st Street, Suite 310
Vancouver, WA 98662

phone (360) 571-2049
fax (360) 253-3196

## *Consent to Use or Disclose Clinical Information*

I authorize Jack Litman, Ph.D. to use and disclose the health care information for the purpose of ***Treatment*** (such as coordinating your care with your primary physician or other health care professionals), ***Payment*** (such as billing your insurance company and determining eligibility of your health benefits) and routine ***Health Care Operations*** (such as scheduling appointments or calling to remind you of an appointment).

This consent form is being provided to you with an attached ***Notice of Privacy Practices.*** Please review this ***Notice of Privacy Practices*** for additional information about the uses and disclosures of protected health care information described in this Consent prior to signing this Consent.

A summary of the ***Notice of Privacy Practices*** will be posted in my office indicating the effective date of the current copy of this document. As more fully explained in the Notice of Privacy Practices, you have the right to request restrictions on how your health care information may be used for treatment, payment, and routine health care operations. You also have the right to request a review of your records or to amend your records; this is more fully explained in the Notice of Privacy Practices.

Please verify that you received the ***Notice of Privacy Practices*** by initialing here: _____

I understand that I have the right to revoke this Consent, provided that I do so in writing, except to the extent that this office has already used or disclosed information prior to my decision to revoke consent.

_____ _____
Signature of Client Date

_____ _____
Signature of legal guardian (if client is a minor) Date

_____
Relationship to client (if client is a minor)

*Jack Litman, Psy.D.*
7600 NE 41st Street, Suite 310 phone (360) 571-2049
Vancouver, WA 98662 fax (360) 253-3196

## *Notice of Privacy Practices*

This document describes how clinical and health care information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice describes the privacy policies followed by this office and any practitioner who might provide "on-call" coverage for me, and applies to the information I have about your health and the services you receive from this office. If you have any questions or requests concerning this notice, please contact me.

I am required by current federal law, effective April 14, 2003, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to give you this notice. It will tell you about the ways in which I may use and disclose protected health information about you and describe your rights and my obligations regarding the uses and disclosure of that information.

**How I may Use and Disclose Protected Health Information (PHI):**

By State law and the ethics of the mental health profession, I must have your written and signed consent to use and disclose health care information for the following purposes:
**For Treatment:** I may disclose health care information in order to provide better clinical services, i.e.; discussing your case with your primary physician or another practitioner for consultation purposes.
**For Payment:** I may use and disclose health information so that services may be billed and paid by you, your insurance company or a third party. It is my policy to release only demographics, diagnosis, date and type of service when I bill third party payers. If more information is required by a payer, I will request your written consent for that disclosure.
**For Routine Health Care Operations:** I may use health information about you in order to run my practice, i.e., appointment reminders. I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contacts.

You may revoke your Consent at any time by giving written notice. Your revocation will be effective when I receive it, but will not apply to any uses and disclosures that occurred prior to that time.

If you are receiving substance abuse treatment, federal and state law require your written Authorization each time I release information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time.

**Special Situations:**
I may use or disclose health information about you without your permission for the follow purposes, subject to all applicable legal requirements and limitations:
**To Avert a Serious Threat to Health or Safety**: Based on professional judgment, I may use and disclose information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
**Required by Law:** Based on professional judgment, I may disclose health care information about you when required by federal, state or local law.
**Lawsuits and Disputes:** If you are involved in a lawsuit, I may disclose health information in response to a court order or subpoena, and I will use my professional judgment about the information to be disclosed.
**Law Enforcement:** I may release health information if required to do so in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
**Family and Friends:** In situations where you might not be capable of giving authorization, because you are not present or due to your incapacity or medical emergency, I may determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only information relevant to the person's involvement in your care.

Additional disclosures are permitted under HIPAA regulation. These will not be made without your authorization and consent. Once information leaves my office and becomes part of any data resource beyond my control, HIPAA permits disclosure in the following circumstances:
**Research:** Health information about you may be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address, or other information that reveals who you are.
**Military, National Security, and Intelligence**: If you are a member of the armed forces, or part of the national security or intelligence communities, military command, or other government authorities may require the release of health information about you. HIPAA also permits the release of information about foreign military personnel to the appropriate foreign military authority.

**Workers Compensation:** Health information may be released for workers compensation or similar programs. These programs provide benefits for work-related injuries.
**Public Health Risks:** Health information may be released in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental injury, reactions to medications or problems with products.
**Health Oversight Activities:** Health information may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
**Information Not Personally Identifiable:** Health information may be disclosed in a way that does not personally identify you or reveal who you are.

**Other Uses and Disclosures of Health Information:**
This office will not disclose your health information for any purpose other than those identified in the previous sections without your specific written Authorization. You may also revoke your Authorization in writing, at any time. If you revoke your Authorization, I will not disclose any further information, but I cannot take back any disclosures already made with your permission. A separate written authorization is required for the release of information regarding HIV or substance abuse treatment. In order to disclose these types of records, I will provide a separate written release that complies with the law governing HIV or substance abuse records.

**Your Rights Regarding Protected Health Information:**
**Right to Review Records:** You have the right to review your clinical, medical and billing records. You must submit a written request to me, the designated privacy officer, in order to inspect your health information. If you request a copy of the records, I may charge a fee for the costs of copying and/or mailing the records. I may deny your request to inspect, review or copy records in certain limited circumstances, such as when I believe exposure to this information may be detrimental to your mental health. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, I will select a licensed mental health care professional to review your request and my denial. The person who conducts this review will not be the person who denied the request, and I will comply with the outcome of the review. You do not have the right to review or copy private psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative proceeding.
**Right to Amend:** If you believe the health records about you are incomplete or incorrect, you may ask me to amend the information. You have the right to request an amendment when the information is kept by this office. To request an amendment, you must submit a clear statement of the requested amendment to the designated privacy contact. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask to amend information that:
- I did not create.
- Is not part of the health information that I keep.
- You would not be permitted to review, inspect, or copy.
- Is accurate and complete.

**Right to an Accounting of Disclosures:** You have the right to request an “accounting of disclosures”. This is a list of the disclosures I have made of clinical information about you for purposes other than treatment, payment, and routine health care operations. To obtain this list, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). I may charge you for the costs associated with providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
**Right to Request Restrictions:** You have the right to request a restriction or limitation on the health care information disclosed about you for treatment, payment or health care operations. You have the right to request limits on disclosures, such as asking that I not call you at your office, or that I not communicate with family members.
**Right to Request Confidential Communications:** You have the right to request that I communicate with you about clinical matters in a confidential way, such as asking that I only contact you at home.
**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this privacy notice. Even if you agreed to receive it electronically, you are entitled to a paper copy.

**Changes to this Notice:**
I reserve the right to change this privacy notice, and to make the revised notice effective for any medical or clinical information I receive in the future. I will post a summary of the current privacy notice, including its effectiveness date, in my office. You are always entitled to a copy of the notice currently in effect.

**Complaints:**
If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

# JACK M. LITMAN, Ph.D.

**7600 NE 41ST Street, Suite 310**
**Vancouver, WA 98662**
**(360) 571-2049**


## EVALUATIONS

**GOOD RELATIONSHIPS ARE BASED ON MUTUAL UNDERSTANDING OF EXPECTATIONS. IT IS MY DESIRE TO BE AS CLEAR AS POSSIBLE ABOUT THESE POLICIES AND PROCEDURES.**

### APPOINTMENTS:

Appointment times vary in length depending on my schedule and the type of evaluation. The appointment begins at the scheduled time, even if you arrive later. Your appointment is held exclusively for you, therefore absences and cancellations will be charged the full amount unless your situation is emergent. These situations will be defined in your first session. Non-emergent cancellations or missed appointments cannot be billed to insurance companies, when applicable, and may jeopardize the completion of your evaluation.

### FEES AND PAYMENTS:

If you or your attorney are requesting an evaluation that is not being subsidized through your insurance or an agency, you are responsible for your account and are expected to pay for all services you receive. I request that you pay at the time of each appointment or at the presentation of the evaluation. Such arrangements are made on a case-by-case basis.

The general fee for evaluation time is $175.00 per 60-minute contact hour. The evaluation will usually involve one or more interviews from one to several hours, and psychological testing. Psychological testing is priced from $160.00 per paper and pencil test to $175.00 per hour of face to face testing. The evaluation may involve getting earlier appropriate records of you, and contacting other individuals you know. I will talk to you about what would be recommended and give an estimate of the cost. There will additional charges for depositions and court appearances. This type of contact is billed at $200.00 per hour. Any additional copy requests after the evaluation is complete, to another agency or office, will be charged a service charge.

### CONFIDENTIALITY:

All issues discussed and information obtained in the course of an evaluation may appear in the final report. If you or your attorney are requesting and subsidizing the evaluation exclusive of a court order, you will be informed of the outcome of the evaluation prior to a report being manufactured. You will then instruct me concerning the completion of the report. If you are instructed to obtain an evaluation by the judicial

system, the court or the agency funding the evaluation will get the final report. In both cases, you may request and receive an interpretation of the evaluation. If a party other than yourself is paying for the evaluation, you will need to request a copy of the evaluation through them.

The law also requires the release of confidential information in additional situations: suspected child or dependent elder abuse, potential suicidal behavior, or threatened harm to another.

In communicating with you I may use e-mail to send you information to be completed and brought to the evaluation. I may also use e-mail to schedule future appointments. As e-mail, Skype, Twitter, and even cell phone communication can be compromised, I prefer direct telephone communication. I will use e-mail only as a last resort, and just for scheduling purposes.

**THE PRACTICE OF PSYCHOLOGICAL EVALUATIONS:**

At your first appointment I will discuss the type of evaluation and my qualifications. You will be informed of the informed of the specific type of evaluation, and given an estimate of its length. You are encouraged to address any questions or concerns about the evaluation to me. You always have the right to discontinue an evaluation. If your evaluation is mandated by a court order, discontinuation will cause the agency and/or court to be alerted, along with the possibility of the production of an evaluation based on the information already gathered. Termination of the evaluation can also occur at my request. Possible reasons for termination might include your unwillingness or inability to assume the financial obligation of the evaluation, or your unwillingness to be evaluated. In appropriate cases, I will provide the opportunity for referral to another evaluator. If you believe you have been treated unprofessionally or unethically, you may contact the State Licensing Board of Professional Psychology. You may also call the Washington State Psychological Association.

**I HAVE READ THE ABOVE POLICIES AND PROCEDURES CONCERNING EVALUATIONS. I UNDERSTAND AND AGREE TO COMPLY WITH THEM.**

SIGNED: _____ DATE: _____

SIGNED: _____ DATE: _____

Signature of parent, guardian, or other family member
(Indicate which by circling)

SIGNED: _____ DATE: _____

Jack M. Litman, Ph.D.
Licensed Psychologist, Washington #958
NCC AP Master Addiction Counselor

# JACK M. LITMAN, Ph.D.

**7600 NE 41ST Street, Suite 310**
**Vancouver, WA 98662**
**(360) 571-2049**


**PATIENT COPY**

## EVALUATIONS

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SIGNED: _____ DATE: _____

SIGNED: _____ DATE: _____

Signature of parent, guardian, or other family member
(Indicate which by circling)

SIGNED: _____ DATE: _____

Jack M. Litman, Ph.D.
Licensed Psychologist, Washington #958
NCC AP Master Addiction Counselor

# INTAKE EVALUATION (ADULT)

**To be completed by client**
***Your information is important. Please answer as completely as possible.***

Client's name: _____ Today's Date: _____

Partner's name (if being seen as a couple): _____

Address: _____ City, State, ZIP: _____

Telephone: _____ _____ E-Mail:
home May we leave messages? Y/N _____

_____ _____
cell May we leave messages? Y/N

_____ _____
work May we leave messages? Y/N

Gender (M/F): ___ Age: ____ Date of Birth: ____/_____/_____ Marital Status: _____

Others living in the home (name, birth date, relationship to client):

_____ ___/____/____ _____, _____ ____/____/____ _____

_____ ___/____/____ _____, _____ ____/____/____ _____

_____ ___/____/____ _____, _____ ____/____/____ _____

Education – Self: _____ Education – Partner: _____

Occupation – Self: _____ Occupation – Partner: _____

Employer – Self: _____

Social Security # – Self: _____ Social Security # – Partner: _____

Emergency contact: _____ Telephone: _____

Referred by: _____

**Insurance Information**

Name of Insured: _____ Insured date of birth: _____
Address of Insured: _____ City, State, ZIP: _____
Relationship of client to Insured: _____ Employer of Insured: _____
Primary insurance company: _____ Phone: _____
Insurance company address: _____ City, State, ZIP: _____
Insurance identification number: _____ Group number: _____

Secondary insurance company: _____ Phone: _____
Name of secondary insured: _____ Date of birth: _____
Secondary insurance address: _____ City, State, ZIP: _____
Secondary identification number: _____ Group number: _____

***PATIENT OR AUTHORIZED PERSON'S SIGNATURE***

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____ Date: _____

Client's Name: _____

**Presenting Problem**

Describe the problem(s) that brought you here today:

Check any of these symptoms you are having:

| | | | |
|---|---|---|---|
| ___ | Depression | ___ | Feeling hopeless |
| ___ | Extreme sadness | ___ | Feeling tearful |
| ___ | Trouble concentrating | ___ | Change in sleeping habits |
| ___ | Memory problems | ___ | Lack of energy |
| ___ | Change in eating habits | ___ | Weight changes |
| ___ | Extreme happiness | ___ | Change in sexual interest or function |
| ___ | Trouble performing job | ___ | Conflicts with friends or family |
| ___ | Lack of enjoyment of usual activities | ___ | Feeling stressed |
| ___ | Self esteem problems | ___ | Easily irritated |
| ___ | Perfectionism | ___ | Feeling guilty |
| ___ | Obsessions or compulsions | ___ | Feeling nervous |
| ___ | Feeling fearful | ___ | Sudden feelings of panic |
| ___ | Physical complaints of pain | ___ | Muscle tension |
| ___ | Problems with anger | ___ | Acting violently |
| ___ | Thoughts of hurting yourself or others | ___ | Thoughts of killing yourself or others |
| ___ | _____ SYMPTOM | ___ | _____ SYMPTOM |

This space reserved for additional comments by clinician:

Client's Name: _____

**Have you ever been in counseling before?** Yes ___ No ___

If you have been in counseling before, please describe it below. Start with the most recent time first.

When? (dates): _____ Who did you see? _____
Explain what happened:

When? (dates): _____ Who did you see? _____
Explain what happened:

**Have you ever been psychiatrically hospitalized?** Yes ___ No ___

For what reason?

When and where? _____

**Have you been treated for a drug or alcohol problem?** Yes ___ No ___

When and where? _____

**Medical information**

Have you seen a doctor within the last year? Yes ___ No ___
Why have you seen a doctor?

Who is your doctor? Phone:
Are you taking any medications, prescription or over-the counter? Please list them:

Do you have any allergies? Yes ___ No ___ Please describe them:

| **Substance use history** | Current | Past | No |
|---|---|---|---|
| Do you use/have you used tobacco (any form)? | ___ | ___ | ___ |
| Do you use/have you used alcohol? | ___ | ___ | ___ |
| Do you use/have you used caffeine (any form, including cola drinks)? | ___ | ___ | ___ |
| Do you use/have you used recreational drugs? | ___ | ___ | ___ |

**JACK M. LITMAN, Ph.D.**

**Clinical & Forensic Psychology**

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
Phone 360-571-2049
Fax 360-253-3196

I received my doctorate from the University of Missouri at Kansas City in 1979. Before that, I unknowingly started my graduate school "on the job training" by working with youngsters in the Kansas City Parks and Recreation program for six summers, from the time I was a high school senior through college. After obtaining my Masters degree I was a counselor in the Jackson County, Missouri Juvenile Justice Center in Kansas City and a psychiatric medic with the US Army. I also worked at a large urban community college for nine years where I counseled students and taught general psychology. While in the doctoral program, I also taught several masters' degree courses.

After I received the doctorate, I began my post-doctoral internship working with a noted forensic psychiatrist in Santa Fe, New Mexico. I continued this internship as a staff psychologist at the Penitentiary of New Mexico where I eventually became Chief of Mental Health Services. Four years later I came to the Pacific Northwest and began work as a psychologist at an inpatient addiction treatment center and started a private practice. This practice involves psychotherapy with adolescents to adults and psychological evaluations or forensic psychology.

I now have over thirty years of experience in a number of areas of counseling and psychology. I have expertise in planning and management of mental health delivery systems, diagnostic evaluations, and expert witness testimony. I have been a presenter at a number of workshops and television programs in Missouri, New Mexico, Oregon, and Washington that have dealt with topics such as communication systems, bereavement, adoption, attachment, alcoholism, and the treatment of the mentally ill offender. I also have expertise in the treatment of minority populations.

In 1991 I received levels I and II training (four days) in the application of Eye Movement Desensitization Reprocessing (EMDR). This procedure seems to utilize the facilitation of rapid eye movement to metabolize or eliminate emotional trauma from both historical and present day traumatic experiences. This has now become an important part of my therapy approach when working with individuals who want relief from their exposure to traumatic incidents.

In 1996 I received a proficiency certification in the Treatment of Alcohol and other Psychoactive Substance Use disorders from the American Psychological Association's College of Professional Psychology.

In November of 2007 I became certified as proficient in the application of Microcurrent Electrical Therapy and Cranial Electrotherapy Stimulation. I use this training as an adjunctive application in the treatment of depression, anxiety, sleep disturbance, executive function issues, and for pain management.

My theory or frame of reference involves Gestalt, Transactional Analysis, and developmental constructs. I am also knowledgeable and supportive of the "twelve-step" program for personal recovery of addicts, alcoholics, adult-children, and co-dependents.

I hold a license to practice psychology in Washington State and am a member of the Washington State, Oregon State, and American Psychological Associations.

# One Park Place

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
Telephone: (360) 253-6425
Fax: (360) 253-3196

**Margret Anderson, LCSW**
**Kathleen Bruhn, Ph.D.**
**Tracy Clason, ARNP**
**Carla Crockford, ARNP**
**Harry Dudley, Psy.D.**
**Megan Dye, ARNP**
**Shelley Geil, ARNP**
**Jack Litman, Ph.D.**
**Jacqueline Moore, ARNP**
**Vicki Paulus, ARNP**
**Walter Spafford, LCSW**

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**From I-5 (either direction)** take the **Orchards, SR 500 Exit (Exit 2)**. Go approximately 4 miles **east on SR 500,** then take the **Andresen Exit**. Go **LEFT (north) on Andresen**. After going under the overpass (see below)*****

**From I-205 coming from the SOUTH** take **EXIT 30C (Orchards, Vancouver, SR 500)**. **Bear LEFT** on the exit so you end up on **SR 500**, heading **west towards Vancouver**, not Orchards. After passing Vancouver Mall, take the **Andresen exit**; and turn **RIGHT (north) on Andresen** (see below).*****

**From I-205 coming from the NORTH** take **Exit 30 (Orchards, Vancouver, SR 500)**. **Bear RIGHT onto SR 500**, heading **west towards Vancouver**.
After passing Vancouver Mall, take the **Andresen exit**; and turn **RIGHT (north) on Andresen** (see below).*****

***From Andresen Road,** turn **RIGHT (east) onto NE 40th Street**, which is clearly marked with a traffic light (US Bank and Comcast Cable are on the corners). **The road will curve left and change into 72nd Avenue**. Take the FIRST **RIGHT onto NE 41st Street**. We are in the **fourth building on the left side**. A marker at the street says "**One Park Place**". The awning at the front entrance says "One Park Place" and "7600". We are on the third floor in **Suite 310**.

*****

**Parking:** Use any available space (except "disabled"). Several one-hour "Visitor" spaces are available in the front of the building. There is also plenty of parking on the top level of the parking structure immediately to the west, behind "Two Park Place". (Enter the lot on the west side of that building).