Jack Litman, Ph.D.

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

phone (360) 253-6425
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.

ONE PARK PLACE
7600 NE 41ST STREET, SUITE 310
VANCOUVER, WA 98662
(360) 253-6425
(360) 571-2049 VOICE MAIL

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

APPOINTMENTS:

Appointments can vary in length of time depending on the circumstance. They are usually 45 to 50 minutes, but can also be 75 to 80 and 25 to 30 minutes. Your appointment length will be made clear to you. This 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**, e.g. you have a significant cold or the flu, your child is ill and your care is required, a family member is in an acute state, etc. Thus, barring an emergent situation once your appointment has been agreed upon, you are financially accountable for this time. **(THERE IS NO 24 HOUR NON-EMERGENT CANCELLATION.)** Missed or canceled appointments cannot be billed to insurance and will be billed to you.

FEES AND PAYMENTS:

You are responsible for your account and are expected to pay for all services you receive. I request that you pay, in full, at the time of each session unless I am a preferred provider with your insurance company and you are required only to make a co-payment. All co-payments are due at the time of your appointment and are given directly to me. The fee for therapy is $225.00 for an initial interview of 60 minutes. Sessions thereafter are from 45 to 50 minutes, at the rate of $150.00 for individual therapy, $175.00 for family or couples therapy, and $150.00 for a family consultation without the client present. Charges for administration, scoring, and interpretation of psychological tests, reports, depositions, court testimony, and extended telephone consultations will be discussed before their use. Accounts without an acceptable payment for 90 days may be referred to collections.

INSURANCE:

Most, but not all, insurance plans cover Mental Health Services. If you are unsure or have questions, call your insurance company to inquire if your plan covers **OUTPATIENT MENTAL HEALTH SERVICES**. Insured patients are expected to keep their accounts current. Even though an insurance claim is filed, you will receive a statement of your account each month if your portion of your account is in arrears. You are responsible for payment of your account unless I have a “Hold Harmless” agreement with your insurance carrier, as a part of being a preferred provider. In this case you are only responsible for your co-pay. I can send a bill to your primary and secondary insurance carrier. In order for me to do this, you need to provide me with that insurance information. If your insurance company is involved with a managed health plan, this plan could require access to your records and will likely ask me to furnish regular reports on your status. If you have an account with Labor & Industries as a result of an industrial claim, I am required to send your chart notes after each session to receive payment. It is also important to understand that a “managed health plan” is just that. Thus, each situation is evaluated separately by the “managed health plan”. You cannot assume that the maximum mental health benefit of your insurance will be attainable. Moreover, Managed Health Plans focus on symptom reduction and relief. By nature, they emphasize brief therapy and do not see long term therapy that focuses on personality change, as part of their plan.

CONFIDENTIALITY:

All issues discussed in the course of therapy are considered confidential, unless released by you in writing. However, there are some limits to confidentiality. By law, information concerning treatment or evaluation may be released only with written consent of the person treated or such person's parent or guardian. However, the law also requires the release of confidential information in three situations: suspected child, elder, and adult dependent abuse, potentially suicidal behavior, or threatened harm to another. Under certain circumstances, the court may subpoena treatment records. Please ask me to cover such circumstances. If your insurance is providing any reimbursement for Mental Health Services, they will also require a diagnosis and may ask for periodic reports of your treatment. Any release of confidential information will be discussed with you. Though the office is comprised of individual practitioners, there is a central reception and waiting area. The office support staff has a common appointment system. Your personal file, however, is kept secure. Should I not be reachable in an emergency, the therapist available, or on call for me, may ask that you identify yourself. 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. Finally, your confidentiality cannot be assured if your account becomes seriously delinquent as seriously delinquent accounts with no provision for payment may be turned over for collection.

EMERGENCY CALLS:

The office phone is answered by a receptionist in most situations, during normal business hours. If you are calling after hours, you may leave a message with my voice mail. I will attempt to call you back in a timely manner. If you need faster assistance you may call any of the following crisis numbers: 911, (360) 696-5232 or (360) 256-2064, or Columbia River Mental Health at (360) 993-3000.

THE PRACTICE OF PSYCHOTHERAPY:

During the first few sessions, you will be informed of the specific type of treatment and an estimate of the length of your treatment. This estimate may be at variance with what your insurance plan will cover. Modifications and/or alternatives, with their limitations, will be discussed. You are encouraged to address your questions or concerns about your treatment, to me. You have a right to discontinue therapy or request a different therapist, provided you have not been mandated to therapy by an agency. If you are mandated to treatment, the agency would also be involved in such a decision. **You are asked to discuss your termination decisions <u>in the therapy sessions</u>**. Termination of therapy can also occur at my request. Possible termination reasons might include me no longer being able to assist you or that you're no longer willing to assume your financial obligations of treatment. If you believe you have been treated unprofessionally or unethically, you can notify the Licensing Board of Professional Psychology.

I UNDERSTAND THAT BY MY PARTICIPATION IN THERAPY, I AM IN AGREEMENT WITH THE AFOREMENTIONED POLICIED AND PROCEDURES.

SIGNED: _____ DATE: _____
Client

SIGNED: _____ DATE: _____
Signature of parent/guardian or other family member

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

JACK M. LITMAN, Ph.D.
ONE PARK PLACE
7600 NE 41ST STREET, SUITE 310
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PATIENT COPY

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SIGNED: _____ DATE: _____
Client

SIGNED: _____ DATE: _____
Signature of parent/guardian or other family member

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

INTAKE EVALUATION (CHILD)

To be completed by parent

Child's name: _____ Today's Date: _____

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

Custodial parent(s) name: _____

Address: _____ City, State, ZIP: _____

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

_____ _____ _____
Mother cell, work (please indicate) May we leave messages? Y/N

_____ _____
Father cell, work (please indicate) May we leave messages? Y/N

Grade in school: _____ School: _____

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

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

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

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

Immediate family living outside the home (name, birth date, relationship to client):

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

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

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: _____

Child's Name: _____

Presenting Problem

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

Check any of these symptoms that the child has been having:

___ Depressed mood
___ Extreme sadness
___ Trouble concentrating
___ Change in sleeping habits
___ Security blanket or object
___ Bedwetting
___ Change in eating habits
___ Problems getting along with family
___ Doesn't seem to enjoy usual activities
___ Trouble doing schoolwork
___ Feeling stressed
___ Low self esteem
___ Perfectionistic
___ Worries
___ Feeling fearful
___ Physical complaints of pain
___ Anger outbursts
___ Running away
___ Has hurt or cut on themself
___ Thoughts of killing self
___ Feels hopeless
___ Tearful / crying spells
___ Memory problems
___ Lack of energy
___ Stuttering
___ Thumbsucking
___ Weight / appetite changes
___ Problems getting along with friends
___ Feelings of extreme happiness
___ Truancy
___ Irritability
___ Isolation / withdrawal
___ Expresses feelings of guilt
___ Seems nervous
___ Sudden feelings of panic
___ Tense / uptight
___ Acting violently
___ Harm to animals
___ Firesetting
___ Thoughts of killing others

This space reserved for additional comments by clinician:

Child's Name: _____

Have you worked with the child's teacher or school counselor? Yes ___ No ___
If so, please describe it below.

Name of teacher or counselor: _____ Date(s): _____
Explain what happened:

Has the child ever been in counseling before? Yes ___ No ___
If so, 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:

Has the child been prescribed any psychiatric medications? Yes ___ No ___
If yes, please describe:

Substance use history (if applicable)	Current	Suspected	Past	No
Does the child use tobacco (any form)?	___	___	___	___
Does the child use alcohol?	___	___	___	___
Does the child use caffeine (any form, including cola drinks)?	___	___	___	___
Does the child use recreational drugs?	___	___	___	___

Child's Name: _____

Medical information

Has the child seen a doctor within the last year? Yes ___ No ___
What was that for?

Who is the child's doctor? _____ Phone: _____

Is the child taking any medications, prescription or over-the-counter? Yes: ___ No: ___
Please list any medications the child is taking:

Please list any major medical problems the child has had, such as chronic illness, serious illness, operations, injuries or trauma to the head, etc.:

Does the child have allergies to anything? Yes ___ No ___
Describe any allergy problems the child has:

Does the child have any problems with sleeping? Yes ___ No ___
Does the child have any problems with eating? Yes ___ No ___
Does the child have any problems with toileting? Yes ___ No ___
Describe the problem(s):

Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual, or emotional)? Yes ___ No ___
Please describe the relevant issue(s):

Child's Name: _____

Developmental history

	Yes	No
Were there any problems with the pregnancy or delivery of the child?	___	___
Any problems with eating, sleeping, or crying spells (colic, nightmares, etc.)?	___	___
Any difficulties or delays in walking, talking, toilet training?	___	___
Have there been any family crises such as marital separation or divorce?	___	___
Have there been any mental health problems in the family of origin?	___	___
Have there been any substance use or abuse issues in the family?	___	___

Briefly describe the child's relationship to parents:

Briefly describe the child's relationship to siblings:

Briefly describe the child's temperament:

School history

When did the child start school?

Were there any problems when the child started school? Yes ___ No ___

What problems have come up during the school years?

What grades is the child getting?

Describe any changes in the child's school performance:

How does the child get along with his or her teachers?

How does the child get along with his or her friends or peers in school?

What are the child's favorite subjects or school activities?

What subjects or activities does the child have problems with?

JACK M. LITMAN, Ph.D.
Clinical & Forensic Psychology

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
Phone 360-253-6425
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**.

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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).