Robert Jackman, LCPC

The following information is kept confidential: It will not be released to any other party without your specific written permission.

Name		Date
Address		
City	State	Zip
Approved phone #:	Approved email:	
Emergency Contact:		
Date of birth	Age	How did you hear about me?

Relationship status ☐ Single ☐ Dating ☐ Significant Other ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Years

The most important people in your life, relationship and stress level (1 = low stress to 10 = high stress)

Name	Relationship	Stress level
Name	Relationship	Stress level
Name	Relationship	Stress level
Name	Relationship	Stress level
Name	Relationship	Stress level

Employer	Job Title

What are your goals for therapy?

Stress in your life (1 = low stress to 10 = high stress, note any key points for discussion)			
Relationship related stress		Work related stress	
Family related stress		Financial related stress	
Health related stress		Traumatic related stress	
Legal issue related stress		Addiction related stress	

For higher stress issues, how long has this been present in your life?
Are there any physical issues that may impact your mental health?
Describe if your family has a history of mental illness or substance abuse / dependence
Legal Issues (past or present, including DUIs)

Confidential Mind and Body Checklist

Circle the number for any **current** issues you are facing, and place an **X** next to any **past** issues.

1. Fatigue and exhaustion	2. Problems with memory
3. PMS	4. Mind wandering
5. Allergies	6. Mind racing
7. Mind confusion	8. Obsessive thoughts or worry
9. Headaches and / or migraines	10. Anorexia
11. Mood swings (happy then sad)	12. Bulimia
13. Anger (rage, explosive anger)	14. Overeating
15. Supersensitive (cry at anything)	16. Lack of sexual arousal
17. Depression	18. Inability to orgasm
19. Food cravings	20. Unable to maintain erection
21. Feeling out of control	22. Unable to ejaculate
23. Wondering what others are thinking	24. Sexual related infections
25. Monitor or control others behavior	26. Jaw grinding at night
27. Hopeless or helpless feeling	28. Poor or interrupted sleep
29. Suicidal thoughts or feelings	30. Low or high blood pressure
31. Homicidal thoughts or feelings	32. Carry tension in shoulders
33. Joint / muscle aches	34. Carry tension in < >
35. Irritable bowel	36. Body trauma / accidents / fights
37. Racing heart related to anxiety	38. Addicted to pornography
39. Panic attacks	40. Addicted to spending

Robert Jackman, LCPC

Psychotherapy

Fee and Therapy Agreement

Please Initial

☐ **Payment of Fees:** Payment for each session is required at the time of the appointment unless you have in network BCBS, Aetna or Magellan PPO insurance or you want us to bill your out of network insurance. Sessions are **55 minutes** in length and the fee is **$180.00** per session. Copays and coinsurance are due at the time of service. Should it ever be necessary to change your fee, you will be informed in advance and have the opportunity to discuss the matter with my office. **If I do not take your insurance, I will work with you on the price of services.**

☐ **Cancellations:** Notification of at least **24 hours** must be received to cancel an appointment.

Cancellations must be made to **voice mail** or **Text** at (630) 721 - 5765.

For same day cancellations, you will be charged a **$100.** fee

For no call, no show cancellations, you will be charged the full fee of **$180.00. My office does not send out reminder texts or emails. Please keep track of your next appointment day and time.**

☐ **Insurance:** it is your responsibility to check with in network BCBS, Aetna or Magellan PPO insurance plans regarding pre-certification requirements, number of sessions available, deductibles, copays and other terms. If you have not met your deductible you will probably be paying the PPO rate. I am on the following panels: **BCBS, Aetna and Magellan** – PPO only. I cannot bill Medicaid or Medicare. If you have another insurance check to see what they will pay for out of network. **You will be responsible for the difference between the out of network rate and my session fee rate.**

☐ **Insurance claims** will be filed on your behalf by my billing service, Medical Office Services. MOS maintains strict patient confidentiality and only contacts your insurance carrier regarding claims and payment of fees and no other matter regarding your care. Statements are sent to your email (please check spam folder as well) look for **statements@medicalofficeservices**. Your statement email will have a link where you will need to sign-in to the patient portal and establish an account to pay your bill.

☐ **You can use your FSA, HSA or credit card as payment through the patient portal in your emailed statement. You can also pay via Zelle to my phone number or email: r_a_jackman@hotmail.com.** If I do not take your insurance, I will work with you on the price of services.

Fee agreement acknowledgement _____ Date _____

Financial responsible party (if different) _____ Date _____

Patient Agreement and Authorizations

Consent for treatment: I hereby consent to the treatment provided by Robert Jackman, LCPC for Mental Health. I authorize the mental and physical health care services deemed necessary or advisable by my caregiver to address my needs.

Authorization for release of personal health information: I authorize the use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Robert Jackman LCPC. I authorize Robert Jackman LCPC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Robert Jackman, LCPC may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agents.

Assignment of insurance benefits / payment guarantee / collection fee: I authorize BCBS, Aetna and Magellan or out of network payments to be made directly to Robert Jackman LCPC for insurance benefits payable to me. I understand that I am financially responsible to Robert Jackman LCPC for any covered or non-covered services. If any amount becomes overdue, and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

Privacy Policy: I acknowledge having received Robert Jackman LCPC's "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in this policy. I understand that I may revoke in writing my consent for release of health care information, except to the extent Robert Jackman LCPC has already made disclosures with my prior consent.

Patient or Authorized Person Signature Date

Witness Date

Release of information: I hereby authorize the release of any information necessary to process my claim to my insurance company(ies) including any managed care and their agents or employee assistance programs. I also hereby authorize payment of benefits directly to Robert Jackman LCPC. I understand that I am responsible for any unpaid balance due. I permit copies of this authorization to be used in place of the original. **I also understand that appointments cancelled within less than a 24 hour notice may be assessed a cancellation fee and is not billable to insurance companies.**

Patient or Authorized Person Signature Date

Insured Signature (if different than above) Date

Robert Jackman LCPC

Effective Jan 1, 2022

Notice of Privacy Practices

We respect patient confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by Robert Jackman, LCPC.

Privacy contact: If you have any questions about this policy or your rights contact Robert Jackman, LCPC at (630) 721 – 5765.

Use and Disclosure of Protected Health Information

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond this office. This includes for:

Treatment: We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside my office that we are consulting with or referring you to.

Payment: With your written consent, information will be used to obtain payment for the treatment and services provided. This may include contacting your health insurance company for prior approval or planned treatment or for billing purposes.

Healthcare Operations: We may use information about you to coordinate our business activities. This may include setting up your appointments and reviewing your care.

Information disclosed without your consent: Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow up Appointments / Care: Robert Jackman, LCPC may contact you about scheduling appointments or information about treatment alternatives or other health related benefits and services that may be of interest to you. Robert Jackman, LCPC will leave appointment information on your voice mail or e-mail unless told otherwise

As required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide public health information such as communicable diseases or suspect abuse, and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners: We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

Governmental Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. There also might be a need to share information with the FDA related to adverse events or product defects. We are also required to share information if requested with the U.S. Department of Health and Human Services to determine

our compliance with federal laws related to health care and to Illinois state agencies that may fund our services.

Criminal Activity or Danger to Others: If a crime is committed on our premises or against Robert Jackman, LCPC, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur.

Patient Rights: You have the following rights under Illinois Law:

Copy of Records: You are entitled to inspect the medical record that has been generated about you. We may charge you a reasonable fee for copying and mailing your record. Records are kept for seven years and afterwards are shredded per federal law.

Release of Records: You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you may wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record: You may ask us not to use or disclose part of the medial information. This must be in writing. Robert Jackman, LCPC is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to Robert Jackman, LCPC.

Contacting You: You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

Corrections: If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact Robert Jackman, LCPC. In certain cases, we may deny your request for an amendment and you have a right to file a statement that you disagree with us. We will then file our response and both your response and our response will be added to your record.

Accounting for Disclosure: You may request an accounting of any disclosures we have made related to your confidential information except for information we used for treatment, payment or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we are required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to Robert Jackman, LCPC. We will notify you of the costs involved in preparing the list.

Questions and Complaints: Contact this office and you may also contact the U.S. Department of Health and Human Services if you believe Robert Jackman, LCLC has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy: Robert Jackman, LCPC reserves the right to amend this policy in accordance with the needs of Robert Jackman, LCPC and changes in state / federal law.