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:			
Your 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.

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 BCBS, Aetna, Humana, or Magellan PPO insurance. We do not send claims to any out of network insurance. Sessions are **55 minutes** in length and the fee is **$190.00** per session. Copays and coinsurance are billed after we receive your EOB. 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 via email: r_a_jackman@hotmail.com or to **voice mail** or **Text** at (630) 721 - 5765.

For same day cancellations (less than 24 hour notice), you will be charged a **$100.** fee

For no call, no show cancellations, you will be charged the full 55 minute session fee of **$190.00. My office does not send out reminder texts or emails. Please keep track of your next appointment day and time. If you're not able to make it in, we can have a virtual appointment instead.**

Insurance: it is your responsibility to check with in network BCBS, Aetna, Humana, 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, Humana and Magellan** – PPO only. I do not bill Medicaid or Medicare. We do not submit to any other insurance plans and no HMO plans.

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@medicalofficeservicesinc.com**. Your statement email will have a link where you will need to sign-in to the patient portal and establish an account to check on the status of your bill.

Credit Card on File billing: You can use your FSA, HSA or credit card as payment. Please acknowledge and sign the Credit Card on File Policy. You can also pay via Venmo @RobertJackmanTherapy, or 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 _________________

Robert Jackman, LCPC

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, Humana, 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

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 our biller; Medical Office Services, Inc. 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.

Robert Jackman, LCPC

Robert Jackman Psychotherapy – Credit Card on File Policy

Effective October 1, 2025

Why we're requesting a credit card on file:

To make payments easier and more secure, we're introducing a **Credit Card on File** system — similar to what you've experienced when booking a hotel or renting a car. With your credit card on file you will not need to go into the patient portal to pay your balance as this will automatically occur as we receive your explanation of benefits each month.

Your card will only be charged if there's a balance due after your insurance has processed your claim. All card information is stored securely, encrypted, and kept off-site — never in our office.

How it works

1. **At your first visit** – We'll ask for your credit card information. (HSA and Primary Card)
2. **Secure storage** – Your card details are encrypted and stored safely by our payment processor (Medical Office Services, Inc.). We never keep your full card number in our office.
3. **After your visit** – Once we receive your Explanation of Benefits (EOB) from your insurance company, we'll email you a statement (sent the first week of the month).
4. **Payment** – If there's a balance you're responsible for, your card will be charged for that amount.

Benefits for you

With a card on file, you can:

- AutoPay balances and co-pays quickly and easily with your preferred card
- If you have an HSA account we process that card first, then go to your Primary card.
- Receive email notifications and receipts for every charge

You still have **all your rights** to dispute charges or question your insurance company's decisions. You can always check your activity through the patient portal throughout the month.

When will my card be charged?
After your insurance processes your claim, you'll receive a statement from statements@medicalofficeservicesinc.com showing your balance and we'll charge your card for the amount owed. Statements usually are emailed the first week of each month if you have a balance due. You will not receive a statement if you do not have a balance.

- Charges will appear on your card for the amount due for copays and/or after we have received your EOB
- **No-show or late cancellation fees** ($100. Late cancel fee – less than 24 hours notice, $190.00 no-show, no call fee). Your appointment time of 55 minutes is reserved specifically for you and no one else. We appreciate you honoring of your appointment time and if need be, cancelling with more than 24 hours notice. (If you're not able to make it in for your appointment we can have a virtual session). Exceptions may be made for emergencies.

I acknowledge that my primary card (not HSA card) will be used to charge late or no show/no call missed appointments. We are not responsible for any debit card charges if you choose to register a debit card instead of a credit card.

Please initial your understanding:___________________

Frequently Asked Questions

What's a deductible?
It's the amount you pay out of pocket each year before your insurance starts covering costs. For example, with a $1,000 deductible, you pay the first $1,000 of medical expenses that are submitted to insurance. Claims submitted from all of your medical providers usually go towards your co-insurance or deductible until it is met.

When do I pay for services?
You're responsible for all charges until your deductible and any co-insurance are met.

How will I know my balance?
You can check your deductible status with your insurance company anytime. We'll also review your EOB and send you a statement showing exactly what you owe.

Why do I need this if I always pay my bills?
We apply this policy to all patients to keep things fair and to make payments faster and easier.

Is my information safe?
Yes. Under HIPAA, your credit card is considered protected health information. It's encrypted, stored securely off-site, and never kept in our office.

What if I don't have a credit card?
You can use a debit card, HSA, or Flex Plan card. If that's not possible, we can arrange a payment plan, cash, check, Venmo or Zelle. A reminder that if you choose to use a debit card we are not responsible for any debit card charges.

Is this like signing a blank check?
No. It's just like a hotel or rental car hold. You can contact Medical Office Services, Inc. (847-526-0100) if you have any questions regarding your claim status, the amount your insurance company paid and what you owe. You can also check this anytime through the patient portal.

What if I pay on my own?

You will be billed for the amount owed based on the patient agreement you signed on intake.

Is this "balance billing"?
No. We only charge you the amount your insurance says is your responsibility — never more than the contracted rate. Approved plans that we accept and process PPO insurance claims: BCBS, Aetna, Magellan and Humana. We do not submit claims to any other insurance that Robert Jackman Psychotherapy is not contracted with.

What if my card expires or is declined?
We'll contact you to update your information. You are responsible for any balance.

Can I change my card on file?
Yes, anytime.

What if I think there's a billing error?
We'll review it with you and issue a refund if there's a mistake.

When do I give you my card?
At your first visit, by phone, or by mail. Once entered into our secure system, your full card number is destroyed — we only see the last four digits.

Questions?
We're happy to help. 📞 Call our Billing Office at **847-526-0100**.

I acknowledge that I have read and understood the Credit Card on File policy:

Please sign ____Date:________________

Robert Jackman Psychotherapy **Credit Card Authorization Form**

I authorize **Robert Jackman Psychotherapy** and **Medical Office Services Inc.** (the billing service for Robert Jackman Psychotherapy) to keep my signature on file and to charge my credit card(s) listed below for agreed upon charges, in accordance with the **Credit Card on File Policy**. I understand this authorization will remain in effect until I provide written notice of cancellation.

Health Savings Account HSA (This will be used before your primary card) NOTE: HSA cards cannot be used to pay for missed appointments and your primary card will be used instead.

HSA **Credit Card Type** (circle one): Visa MasterCard Discover Amex

Credit Card Number: ____

Security Code: __________ **Expiration Date (MM/YY):** __________

Name on Card: ____

Primary **Card to Charge (after HSA card is used)**

Credit Card Type (circle one): Visa MasterCard Discover Amex

Credit Card Number: ____

Security Code: __________ **Expiration Date (MM/YY):** __________

Name on Card: ____

HSA/Primary Card Billing Address: ____

City: ______________________ **State:** _______ **Zip:** __________

Phone Number: ____

Email: ____

Patient Name: ____

Date of Birth: ____

Signature: ____________________________________ **Date:** __________

Your card will only be charged for balances you owe after insurance has processed your claim and we have received your EOB – Explanation of Benefits. Card details are encrypted and stored securely off-site; only the last 4 digits are visible to staff. You may update your card information at any time. Thank you.

ROBERT JACKMAN
PSYCHOTHERAPY