

# Jill Buehler Knerr, LCSW

Individual, Pre-Marital, Marital/Couples and Family Therapist

227 West Broad Street, Suite 201 Bethlehem, PA 18018

jbnknerr@rcn.com

www.jillknerrcounseling.com

Phone/Fax: 610.691.2455

---

## Basic Information

Date \_\_\_\_\_

Client's Name \_\_\_\_\_ Phone (H) \_\_\_\_\_

Address \_\_\_\_\_ Phone (W) \_\_\_\_\_

\_\_\_\_\_ Phone (C) \_\_\_\_\_

Email address: \_\_\_\_\_ Please \* which number message can be left

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Education \_\_\_\_\_ Employer \_\_\_\_\_

Referral Source \_\_\_\_\_

May we have your permission to let referral know you came in? \_\_\_\_\_

**CURRENT PROBLEM:** Briefly state the problem for which you want help

## HEALTH INFORMATION

Your physicians name & phone \_\_\_\_\_

Current medical problems \_\_\_\_\_

Medications you currently take (prescription and non-prescription) \_\_\_\_\_

Have you ever seen a counselor, psychologist or psychiatrist before? \_\_\_\_\_

If yes, when and who? \_\_\_\_\_

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

Have you ever been hospitalized for an emotional or drug/alcohol problem? \_\_\_\_\_

If yes, when and where? \_\_\_\_\_

For what reason? \_\_\_\_\_

Whom should we contact in case of an emergency? \_\_\_\_\_

Name

Phone

**CHEMICAL USE HISTORY**

YES

NO

Do you use drugs?

\_\_\_\_\_

\_\_\_\_\_

Do you use alcohol?

\_\_\_\_\_

\_\_\_\_\_

Do you sometimes drink more than you had planned?

\_\_\_\_\_

\_\_\_\_\_

Have family or friends ever expressed concern about your use of alcohol?

\_\_\_\_\_

\_\_\_\_\_

Have you ever been arrested for alcohol related charges (E.g., DUI, public intoxication)?

\_\_\_\_\_

\_\_\_\_\_

Have you ever had episodes where you were unable to remember periods when you were drinking?

\_\_\_\_\_

\_\_\_\_\_

Have family or friends ever expressed concern over your use of drugs?

\_\_\_\_\_

\_\_\_\_\_

Have you ever been arrested for any offense involving drugs?

\_\_\_\_\_

\_\_\_\_\_

Have you ever been treated for drug abuse?

\_\_\_\_\_

\_\_\_\_\_

Have you ever overdosed on drugs accidentally?

\_\_\_\_\_

\_\_\_\_\_

Have you ever purposely-overdosed on drugs?

\_\_\_\_\_

\_\_\_\_\_

Have any members of your family had problems with drugs or alcohol?

\_\_\_\_\_

\_\_\_\_\_

Do you use nicotine?

\_\_\_\_\_

\_\_\_\_\_

**RISK FACTORS**

Do you know anyone who has ever attempted suicide?

\_\_\_\_\_

\_\_\_\_\_

Have you, in the past year, ever considered suicide?

\_\_\_\_\_

\_\_\_\_\_

If yes, please explain

Have you ever attempted suicide?

\_\_\_\_\_

\_\_\_\_\_

If yes, please explain

Have your personal problems affected your job performance in any way?

\_\_\_\_\_

\_\_\_\_\_

If yes, how?

Have you ever been exposed to serious trauma?

\_\_\_\_\_

\_\_\_\_\_

If yes, how?

Have you ever been sexually abused?

\_\_\_\_\_

\_\_\_\_\_

Have you ever been asked or forced to engage in touching, sexual activity against your will?

\_\_\_\_\_

\_\_\_\_\_

**LEGAL HISTORY**

Presently, are you involved in any legal problems?

\_\_\_\_\_

\_\_\_\_\_

Have you had legal problems in the past?

\_\_\_\_\_

\_\_\_\_\_

If yes to either, please explain

# Jill Buehler Knerr, LCSW

Individual, Pre-Marital, Marital/Couples and Family Therapist

227 West Broad Street, Suite 201 Bethlehem, PA 18018

jbknerr@rcn.com

www.jillknerrcounseling.com

Phone/Fax: 610.691.2455

## HEALTH INSURANCE DATA FORM

If you have no Health Insurance coverage please check here , complete sections A, C and D below, and return this form to me. Otherwise, please provide the following information:

A. Patient's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_ Marital status: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

B. Name of the person insured: \_\_\_\_\_

Insured's employer: \_\_\_\_\_ Business phone: \_\_\_\_\_

Address of employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Length of employment there: \_\_\_\_\_

What relationship is the patient to the person insured?  Self  Spouse  Dependent  Other: \_\_\_\_\_

Insurance Company's name: \_\_\_\_\_

Identification #: \_\_\_\_\_ Group # or Enrollment #: \_\_\_\_\_

Plan #/Code or BS #: \_\_\_\_\_

Address to send claims: \_\_\_\_\_

Phone number of insurance company \_\_\_\_\_

Authorization # \_\_\_\_\_ Agreement # \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ per person? Per family? Per year? Per diagnosis? (Circle all that apply)

How much of this limit has been used so far? \$ \_\_\_\_ . Percent reduction for Mental Health? \_\_\_\_%

Limitations: Number of visits: \_\_\_\_\_ Monetary limits: \$ \_\_\_\_\_ per \_\_\_\_ . Lifetime limits: \$ \_\_\_\_\_ .

Does year run from Jan. to Dec?  Yes  No, from \_\_\_\_\_ to \_\_\_\_\_ .

Must a physician refer the client?  Yes  No Is Psychological testing covered?  Yes  No

Does any pre-existing condition rule apply here?  No.  Yes: \_\_\_\_\_

C. If you do not have insurance, how will you pay for these services?

D. I authorize this office to release any information obtained during treatment of this patient which is necessary to expedite any insurance claims on this account. I understand that I am responsible for all charges, regardless of insurance coverage. I authorize the payment of benefits otherwise payable to me, directly to this provider.

\_\_\_\_\_  
Patient's/Parent's/Guardian's Signature

\_\_\_\_\_  
Date

2/2013

# Jill Buehler Knerr, LCSW

Individual, Pre-Marital, Marital/Couples and Family Therapist

227 West Broad Street, Suite 201 Bethlehem, PA 18018

jbknerr@rcn.com

www.jillknerrcounseling.com

Phone/Fax: 610.691.2455

---

## Consent to Treatment

I, \_\_\_\_\_, give my permission and consent to receive psychotherapy from Jill Buehler Knerr, MSW, LCSW.

While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed. I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing. Working through issues can bring up difficult feelings which will be addressed in the therapy.

I understand this therapist is **not** providing an emergency service, and I have been informed to call 911 or go to the nearest Hospital Emergency Room or call Crisis Intervention if I am in a crisis/emergency situation.

I understand regular attendance, fully participating in therapy and following through on recommendations will produce the maximum benefits.

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

I understand that if I do not give **at least 48 hours notice** to cancel a session, I will be charged for the session. This fee is not reimbursable by insurance.

Sessions are 50 minutes long.

I agree to pay \$\_\_\_\_\_ for the initial session and \$\_\_\_\_\_ for each session thereafter. Payment is due at time of service.

### Confidentiality

I understand that every attempt will be made by the therapist to keep conversations that occur in therapy sessions confidential. I further understand that the therapist, by law, must report certain situations. These include:

- A) Actual or suspected child, spouse, or elder abuse
- B) If I threaten to harm or injure another person (including myself). The therapist is required by law to protect the potential victim, which may include contacting that person

I understand that my information may be revealed if records are court ordered.

I understand that information may be disclosed to the insurance company for the purpose of reimbursement.

Additionally, I understand that my therapist receives supervision and might discuss some aspects of my case with her supervisor. I give my permission for her to do this.

I know of no reasons I should not undertake this therapy and I agree to participate fully and voluntarily.

Client(s) Signature: \_\_\_\_\_  
(of patient or a person authorized to consent for patient)

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

\_\_\_\_\_

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

Therapist's Signature: \_\_\_\_\_

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

# Jill Buehler Knerr, LCSW

*Individual, Pre-Marital, Marital/Couples and Family Therapist*

227 West Broad Street, Suite 201 Bethlehem, PA 18018

jbknerr@rcn.com

www.jillknerrcounseling.com

Phone/Fax: 610.691.2455

---

## Notice of Privacy Practices

This form is an agreement between you, \_\_\_\_\_ and me \_\_\_\_\_.  
When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here. \_\_\_\_\_

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form. It can be found on my web site ([www.jillknerrcounseling.com](http://www.jillknerrcounseling.com)).

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.**

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from me.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Description of personal representative's authority

\_\_\_\_\_ Copy given to the client/parent/personal representative

2/2013

## Jill Buehler Knerr, LCSW

*Individual, Premarital, Marital/Couples and Family Therapist*

227 West Broad Street, Suite 201 Bethlehem, PA 18018

[jbknerr@rcn.com](mailto:jbknerr@rcn.com)

[www.jillknerrcounseling.com](http://www.jillknerrcounseling.com)

Phone/Fax: 610.691.2455

---

### **Directions to Office:**

227 West Broad Street, Suite 201

Bethlehem, PA 18018

Phone/Fax (610) 691-2455

Take ROUTE 22 to ROUTE 378 SOUTH, towards Bethlehem. Exit onto EIGHTH AVENUE, EXIT 2. Turn RIGHT at end of ramp onto EIGHTH AVENUE. Turn LEFT at the second traffic light onto WEST BROAD STREET. My office is on the RIGHT, at the corner of SECOND AVENUE and WEST BROAD STREET.

Parking is free on Second Avenue. Parking is \$1 per hour on Broad Street.

My office is on the second floor. Please wait for me in the waiting area on the second floor.