1501 N. University Ave, Suite #412
Little Rock, AR 72207
501-295-6385

Client Information Forms

Client Name_____
(Last) (First) (Middle)
Address: _____

City: _____ State: _____Zip Code_____

Home Phone: ( ) _____ Work Phone: ( ) _____ Ext#_____

Cell Phone: ( ) _____ E-Mail Address: _____

*May we send appointment reminders to this cell phone? _____Yes _____ No
*May we send appointment reminders to this email address? _____ Yes _____ No

Date of Birth: _____ Age: _____

Sex: ____M ___ F Martial Status: ____Single ____Married ____Divorced ____Widowed ____Other

Employer: _____ If student, school attending _____

If dependent child, are custodial parents: ____ Married ____ Separated ____ Divorced ____ Other

IN CASE OF AN EMERGENCY NOTIFY: **Name:** _____
Relationship: _____
Phone: ( ) _____

Referred here by: _____

Primary Insurance Information

Name of Policy Holder_____
(Last) (First) (Middle)
Relationship to Patient (Circle one): Self Spouse Mother Father
Birthdate of Policy Holder: _____
Insurance Company: _____ Phone #: _____
Insured ID#: _____ Group #:_____
Plan Name: _____
Employer: _____Occupation_____ Work phone _____

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the provider for the services provided.

_____ _____
Client Signature Date

leigh hudson LCSW
heal. grow. thrive.

MARRIAGE and FAMILY:

Marital Status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____

How long divorced _____ Number of divorces _____ Length of current marriage _____

Spouse Name _____ Age _____ Occupation_____

Number of Children and Names _____

_____

HEALTH RATING: Excellent _____ Good _____ Average _____ Poor _____ Very Poor _____

Are you currently under a doctor's care? ____ If yes, please explain. _____

Physician's Name: _____ Phone _____

Psychiatrist's Name: _____ Phone_____

Known allergies: _____

Are you currently taking medication? _____ What? _____

Have you ever used drugs recreationally? _____ What and when? _____

Alcohol use: Never _____ Occasionally _____ Often _____ Habitually _____

Have you ever had any major medical or emotional problems? If yes, please explain._____

_____

Have you seen a counselor before today? _____ Who?_____

RELIGION/FAITH:

Do you attend church? _____ How frequently? ____ Occasionally ____ Weekly ____ More than once a week

Are there any recent changes in your faith or church attendance? _____

Please explain _____

SPECIFIC PROBLEM AREAS: Please check any of the following that are **currently** troubling you:

___Adoption	___Depression	___Legal issues	___Religion/Faith Issues
___Addictions	___Divorce/Separation	___Loneliness	___Sexual Abuse/Rape
___Alcoholism	___Eating disorder	___Loss of appetite	___Sexual Addiction
___Anger	___Envy /Jealousy	___Loss of control	___Sexual issues
___Anxiety	___Family issues	___Loss of focus	___Shame
___Apathy	___Fear	___Loss of energy	___Single parent
___Bitterness	___Finances/Debt	___Loss of memory	___Singleness
___Burnout/Stress	___Forgiveness	___Loss of sleep	___Spouse abuse
___Change of lifestyle	___Frustration	___Loss of trust	___Substance abuse
___Child abuse	___Guilt	___Marriage	___Suicidal thoughts
___Children/discipline	___Health/Medical	___Medication Issues	___Self-esteem
___Children/school	___Honesty	___Mid-life	___Trauma/PTSD
___Children/rebellion	___Hormones	___Panic attacks	___Unemployment
___Communication	___Infidelity	___Parent Issues	___Violence/Rage
___Confusion	___In-Laws	___Physical abuse	___Withdrawal
___Crisis/Conflict	___Job problems		___Worry
___Death of loved one			

Patient Information & Consent for Treatment

Thank you for choosing Leigh Hudson, LCSW, PA for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with the procedures and policies of my clinic, please read the following information:

Appointments:

If you need to cancel an appointment, a minimum of 24 hours notice is required. There will be a **$50.00** charge if your appointment is cancelled **within** 24 hours of appointment time. **If you do not call within 24 hours and do not show up for your appointment**, a charge of **$75.00** will apply. In the evenings and on weekends, you may leave a message on my office voice mail, which will accurately record the date and time of your call. Charges for missed appointments are not covered by insurance and will be billed directly to you.

The courtesy call, text, or email that you receive to remind you of your appointment is usually made within 24-48 hours of your appointment. It is your responsibility to know when your appointment is scheduled. Cancelling your appointment with less than 24 hours notice does not allow me sufficient time to offer that session to another client.

I also ask that you be punctual. If you are late, you will receive the remainder of your scheduled time. This is necessary so that I can see the remaining clients at their scheduled times.

Emergencies:

To leave a message for me please call my office at (501) 295-6385, and I will return your call as soon as practicable. If you are in immediate danger, call 911 or go to the nearest emergency room.

Financial Responsibility:

You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual arrangements apply. **Please make checks payable to Leigh Hudson LCSW, PA.** I also may require that a valid credit card be kept on file with me to guarantee payment. You authorize me to apply any charges to a credit card on file for fees that occur as a result of your treatment.

There will be a **$35.00 fee** for checks that are returned as non-sufficient funds or non-payable and for any credit card charges that are rejected by your card. You will receive an invoice from my office letting you know the total amount due. All invoices are due and payable upon receipt. Account balances more than 60 days past due may be turned over for collection. If you have questions regarding your account, please contact me at (501) 295-6385. All correspondence will be sent to the address on your intake forms. If this presents a problem for you, please let me know.

Confidentiality:

Your client records are the property of Leigh Hudson LCSW, PA and shall be treated as confidential. Everything about your care will be held in strictest confidence (with the exception of those circumstances set forth in the Notice of Privacy Practices). If you choose to have me keep a third party informed of your progress in counseling, it will be necessary to complete a "Release of Information" form that will be kept on file.

Please sign below to indicate you have read and understand the above and are consenting to receive treatment by Leigh Hudson, LCSW, PA:

Client or Guardian_____ Date _____

If client is a minor, print name of client: _____

Leigh Hudson, LCSW, PA

Counselor Disclosure Form

(Please Read and Sign Below)

Counselor Disclosure Information

The following information provides you with clarity of the counseling process as well as administrative policies and your rights and responsibilities as a client.

Educational/Professional Background

I received my Bachelor of Arts in Psychology and my Masters of Social Work from the University of Arkansas at Little Rock. I am a licensed certified social worker (LCSW). I am also certified in Eye Movement Desensitization and Reprocessing (EMDR).

My experience includes working with a broad range of issues, as well as a diverse group of clients. I have experience working with clients in individual, group and marital counseling. I have worked with clients ages thirteen and older, and individuals from varying ethnic backgrounds. Some of the issues I have worked with include: acute stress reaction, post-traumatic stress disorder, depression, anxiety, infertility, grief and loss, parenting, blended family, marital/relationship conflict, stress, substance abuse, and emotional/physical/sexual abuse.

I do not prescribe medications. If you are under current medical treatment, and with your express written permission, I will work in cooperation with your doctor(s). If medical treatment is needed, I will recommend competent medical personnel and work in cooperation with them towards your best interests.

Counseling Process

Counseling takes place in the context of a helping relationship in which the therapist works with the client to resolve a problem, change behavior or foster personal growth and awareness.

During the counseling process, you may experience some emotional discomfort related to your problem(s) that can be caused by powerful emotions that are normally either consciously or subconsciously avoided. This psychological pain is a normal part of the growth process towards healing.

After initial evaluation of your problem(s), together we will establish goals, and we will periodically evaluate progress towards attaining those goals. Throughout counseling, I may periodically give homework assignments. I believe your attention to these assignments is just as important as the time we spend in our counseling sessions.

As a Christian counselor, my beliefs inform my practice. But I also understand that not everyone professes to be a Christian. I will never require you to believe the same as I do. But keep in mind that all of our beliefs influence our lives and as such, my beliefs influence my counsel. To that end, I will incorporate into my counsel the timeless truths of scripture and the hope that can be found in the Gospel of Jesus Christ.

Client's Rights and Responsibilities

While I will always strive to offer services that are appropriate and in your best interest, it is your responsibility to determine whether the services are ultimately helpful. You have the right to end counseling at any time without moral, legal or financial obligations other than those already accrued. Complaints and/or grievances may be reported to the Arkansas Social Work Licensing Board, 5800 W. 10th St., Little Rock, AR 72204; 501-372-5071.

As a private practice therapist, I must operate as a small business. This means that unless clients pay their bills, I cannot afford to continue offering services. Appointment times are not automatically held open for you from week to week. It is your responsibility to reschedule at the end of a session.

Confidentiality

Confidentiality is an important element of the counseling process. Your identity, records and ongoing work in counseling will be safeguarded as set forth in my Notice of Privacy Practices, a copy of which has been provided to you.

Acknowledgment

By signing this disclosure and informational statement, you acknowledge having been informed of your rights and responsibilities under regulatory laws for social workers in Arkansas, as well as the counseling process for this particular social worker. In addition, you acknowledge reading and understanding the administrative policies for the counseling practice of Leigh Hudson, LCSW, PA.

_____	_____
Please print name	Date
_____	_____
Signature of Client (or guardian)	Date
_____	_____
Counselor Signature	Date

Effective Date: 02/01/23

Leigh Hudson, LCSW, PA

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.
B. If you have questions about this Notice, please contact: Leigh Hudson, LCSW, PA at 1501 N. University Ave, Suite #412, Little Rock, Arkansas 72207, or call 501-295-6385.
C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI:
1. Treatment. In an emergency, we may use or disclose your mental health information to a physician or other healthcare provider for your protection and the protection of others.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services.
3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Your Authorization. In addition to our use of your mental health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke in writing at any time. However, your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your mental health information for any reason except those described in this notice.
5. To your Family. Family members will not have access to your mental health information unless you give us authorization or in case of an emergency. In the case of a minor, mental health information will only be released for the purpose of payment, scheduling, or an emergency, or for therapeutic purposes at the therapist's discretion. Only a custodial parent or legal guardian can have access to this information.
6. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment. (**Please keep in mind that email and text forms of communication are not encrypted, and as such, your privacy cannot be guaranteed**.)
8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
9. Legal Subpoenas. Your mental health records will not be released by an attorney's subpoena unless we receive written consent from you or pursuant to a lawful order issued by a court. Under circumstances in which you were seen by Leigh Hudson, LCSW, PA, with your spouse, records that pertain to your sessions as a couple cannot be released without consent from each individual.
10. Marketing Health Related Services: We will not use your mental health information for marketing communications without your written authorization.
11. **Abuse or Neglect.** We may disclose your health information to appropriate authorities if we reasonably believe that you, or a minor in your care, are a possible victim of abuse or neglect. We may disclose your mental health information to the extent necessary to avert a serious threat to your health or safety or the health of others. We may disclose your mental health information if we have reasonable cause to believe that you are the perpetrator of child abuse or neglect.
12. National Security. We are required by law to disclose to authorized federal officials mental health information that represents a threat to national security.
D. Your rights regarding your PHI:
You have the following rights regarding the PHI that we maintain about you:
1. Confidential communications. You have the right to request that our practice communicate with you about your mental health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Leigh Hudson, LCSW, PA** at **1501 N. University Ave, #412, Little Rock, AR**

72207, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Leigh Hudson, LCSW, PA at 1501 N. University Ave, #412, Little Rock, AR 72207.** Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient records, including billing records, but not including psychotherapy notes. You must submit your request in writing to **Leigh Hudson, LCSW, PA** at **1501 N. University Ave, #412, Little Rock, AR 72207** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed mental health care professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Leigh Hudson, LCSW, PA** at **1501 N. University Ave, #412, Little Rock, AR 72207**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of disclosures. You have the right to be informed of instances in which your mental health information or records were disclosed, if for reasons other than treatment or payment.
6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Leigh Hudson, LCSW, PA** at **1501 N. University Ave, #412, Little Rock, AR 72207 or call 501-295-6385**.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Leigh Hudson, LCSW, PA at 1501 N. University Ave, #412, Little Rock, AR 72207**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Leigh Hudson, LCSW, PA at 1501 N. University Ave, #412, Little Rock, AR 72207 or call 501-295-6385**.

Leigh Hudson, LCSW, PA
1501 N. University Ave, Suite #412
Little Rock, AR 72207
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Client Consent for Protected Health Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third-party payers.
- Conduct normal healthcare operations such as quality assessments and provider certifications.

I have been provided by Leigh Hudson, LCSW, PA a written *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Parent or Guardian **Date**

_____ _____
Relationship to Client **Date**

Leigh Hudson, LCSW, PA
1501 N. University Ave, Suite #412
Little Rock, AR 72207
501-295-6385

Authorization for Release of Confidential Information

Client Name: _____ Date of Birth _____

I authorize Leigh Hudson, LCSW at Leigh Hudson, LCSW PA to release information to or request information from the individual or entity noted on this authorization.

Purpose of Authorization*:* **Emergency Contact**

Emergency Contact Name: _____

Relationship to Client: _____

Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

_____ _____
Signature of Client **Date**

_____ _____
Signature of Parent or Guardian **Date**

_____ _____
Relationship to Client **Date**