Tameka L. McFarland, MS, LMFT, NCC, CPLC

Signature requested on May 04, 2023

Consent for Treatment and Telehealth Services

Business: Tameka L. McFarland, MS, LMFT, NCC, CPLC
tmcfarland@themftpro.com
1135 Kildaire Farm Rd, Suite 200, Cary, NC, 27511
(919) 415-4720

Recipient: Prospective Client
mcfarlandmft@gmail.com

This contract is between Tameka L. McFarland, MS, LMFT, NCC, CPLC (the "Business") and Prospective Client (the "Client") dated 05/04/2023.

The client is hiring the Business for the services described in this contract. He/She is consenting to the terms of receiving mental health treatment from the above named clinician.

INFORMED CONSENT FOR TREATMENT AND UNDERSTANDING OF
TERMS OF PROFESSIONAL DISCLOSURE AGREEMENT

I have read through and understand the registration and consent packet sent to me by the office of the above-mentioned clinician. I have received a copy of the HIPAA Privacy Notices from this clinician. I have had an opportunity to ask any questions regarding all policies. I understand that I must contact the office number at 919-415-4720 or her mobile number at (252) 219-0206 or email tmcfarland@themftpro.com to schedule/reschedule, or cancel all appointments. I agree to the no-harm contract for the safety of myself and others. I understand that the clinician must report all suspected abuse and neglect of minors and/or elderly persons to authorities as required by state and federal laws. I agree to the assessment of safety regarding self-harm or interpersonal violence for myself, my partner, and other parties directly involved in the therapeutic process with me. I understand that receiving mental health therapy or life coaching services is a not a guarantee of my desired outcome and the risks associated with treatment. If I am seeking family or couples/marital counseling, I understand that the clinician will

not keep secrets of any kind (i.e. child abuse, infidelity, STD transmission, etc.). I understand that she will not disclose those secrets either, but will instead terminate services if they are not disclosed within her specified amount of time to the effected partner/party/family member. I understand and agree that the clinician operates on a “no-collusion” policy and that she will only see couples’ clients individually for the reading of assessment results. I agree to authorize the clinician to release my medical information, including diagnosis and clinical notes, to my insurance company for payment of attended session claims unless I am a self-pay client. I have read and agree to the court appearance policy. I have read and agree to the clinician’s professional disclosure statement and terms. I agree to allow the clinician to contact emergency services and my specified emergency contact person should I experience a medical or psychological emergency during my treatment at her discretion. I understand that it is at the clinician’s professional discretion to involuntarily commit me to a psychiatric facility should she deem me to be a danger to myself or others/and or contact the appropriate authorities including the Department of Social Services or local law enforcement. I understand that in order for me to access my clinical file, I will have to fill out a written request from the office, have it notarized and then present it to the office manager. Once verified, it will be released to me via USPS certified mail within 5-7 business days of my my request being faxed to the office.

REQUIRED FORMS

I understand and agree that each therapy participant that is 18 years of age or older is required to sign a consent for treatment and consent for telehealth services before their initial hourly session. Each therapy participant is also required to complete a clinical initial intake form before their first hourly session begins. For minor children, a legal guardian of the child(ren) must complete the consent form and the intake form for them. If these forms are not completed or received by the clinician prior to the appointment start time, the session will be cancelled by the clinician and a refund of session fees will be processed back the client's original payment method within 2-10 business days after the initial session date.

Minor Child Consent for Treatment

I am the legal parent/guardian of and give my consent for treatment of my child, _____ for mental health services. I understand that I am required to attend the first 3 sessions of therapy with or without my child so that the clinician can complete safety and clinical assessments. I understand that after the third session the clinician will inform me of her professional recommendation for services and if it would be best given individually or within the context of family therapy. I understand that the clinician must report all suspected abuse and neglect of minors and/or elderly persons to authorities as required by state and federal laws. I understand that if it is suspected that the minor aged client is being abused

physically or psychologically, the clinician will report it to the client's local authorities and recommend that treatment continue with the child individually for their safety. I understand that if there is a custody agreement regarding the child and their other parent/guardian, I will need to provide a copy of the custody agreement to the clinician before services can begin. I understand that if the parents/guardians of the child(ren) are married, legally separated/divorced without a custody agreement, or legally separated/divorced with a joint legal custody agreement, the other parent will also have to sign a consent for treatment before services can will begin. I understand that if there are any changes to any legal agreements between the parents of the child, I must provide a copy of the new agreement to the clinician before the child's next scheduled appointment. I understand that once the client turns 18, their rights will be discussed with them and they will need to sign a new set of consents for treatment themselves. I understand that in order for me to have access to their records after their 18th birthday, my child will have the option of completing a release of information authorization form specifying what, if any, information will be disclosed to the parent or any other entity.

Fee for Services

My mental health insurance benefits have been verified and my copay was provided to me in the patient welcome email, via text, or during my initial telephone consultation. I understand that the clinician must submit a diagnosis to the insurance company along with progress notes each time in order for them to pay for services. I agree to receiving and paying using the electronic Square, Inc. invoice the clinician will send me via email 3-7 days before each session. I also understand that I can pay my balance using the client
portal in TheraNest. I understand that this office does not accept checks, CashApp, Venmo, Zelle, wire transfers, or money orders as forms of payment, only debit/credit, or HSA/FSA cards. I understand that if I am due for a refund for any reason, it will be issued back to the original card from which the initial payment was processed within 7-10 business days, and I will receive a receipt of such refund. I understand that session fees are due at least 30 minutes prior to each session. I understand that should I not provide 24 hours-notice to cancel my appointment, I will be charged $50 that must be paid before any other sessions are scheduled. I understand that if I do not pay my no show/late cancellation fee before the next scheduled appointment, the clinician will cancel that appointment and release that spot to another client and not resume services until that fee is paid. I understand that sessions are 53-60 minutes in length. I understand that if I am more than 7 minutes late to my appointment, my clinician has the option to cancel my appointment, or I will forfeit the elapsed time I missed for that session without any refund for those minutes and continue to the end of the
scheduled session. I understand that if I need to leave my session early, I will still be charged the full $100-$150 session fee for that appointment. I understand that if all applicable fees to my account are not paid within 30 days of the date of service or a payment arrangement has not

been made, an attempt to charge my card on file will be made and/or my account will go to a collection agency. I understand and agree that if I miss 3 consecutive appointments, even if I cancel appointments with a 24 hours notice given, Tameka L. McFarland, MS, LMFT, NCC, CPLC will send me a notice of termination of services with information to obtain referrals for continued therapeutic services with another clinician of my choosing. I understand if I have an unpaid balance to Tameka L. McFarland, MS, LMFT, CPLC and do not make satisfactory payment arrangements, my account may be placed with FedChex an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts. In order for Tameka L McFarland, MS, LMFT, CPLC or their designated external collection agency to service my account. I agree that the designated external collection agency are authorized to (i) contact meby telephone at the telephone numbers I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and or use of an automatic dialing device, as
applicable. Further more, I consent the designated external collection agency to share personal contact information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification. I understand and agree to the termination of services indefinitely with Tameka L . McFarland, MS, LMFT, CPLC if my account is ever placed with an external collection agency. I understand that it is my responsibility to request a sliding scale fee in writing with the clinician and once that fee is agreed upon, I will sign a contract regarding that fee. I understand that in order to qualify for the sliding scale fee, I must provide proof of financial hardship (i.e. Letter verifying Unemployment benefits, copy of tax returns for the previous
year before the date of service, proof of a qualifying life event)

Couples Therapy: PREPARE/ENRICH/Gottman Relationship Check-Up

I agree to and understand that a requirement for my participation in couples therapy involves my completion of the PREPARE/ENRICH assessment or the Gottman Relationship Check-Up for couples. I understand that this self-report of my experiences in my current relationship is scientific-based data that my clinician will use to determine the course of treatment for myself and my partner. I agree to pay the fee of $50 for the assessment via Square, Inc. invoice. I understand that after I pay the invoice, my clinician will set up the assesment and an email invitation link to myself and my partner from the company directly will be sent to complete the assessment. I understand that this
assessment is not covered by insurance. I also understand that once this assessment is

completed by myself and my partner, we will both receive access to the summary results after our clinician meets with us to discuss those results.

Court Appearance Policy

Court appearances by the clinician, Tameka L McFarland, MS, LMFT, NCC, CPLC, for your case require the clinician to be absent from other clients and to focus on your family only. It takes time to prepare and in some cases your attorney may want to speak with me regarding information they need regarding the case. This may include permission for the release of your session progress notes. This could also include preparation if I need to testify on your case. Due to the time and dedication required to appear and prepare for legal matters, there are additional costs associated with court appearances. By signing this form, you agree and understand the following:

• I will only appear in court if subpoenaed by a judge. If your case requires me to travel more than a 20-mile radius from the office, you agree to pay the cost of $. 75/per mile per day for every mile over.
• You agree to pay $150/day for each day I am required to appear in court.
• If your case requires an overnight stay, you agree to pay for the cost of a hotel room up to $139 per night.
• If your case requires an overnight stay, you agree to pay for 3 meals at a total rate of $35 per day.
• Once we have confirmed my requirement to appear on your behalf, we will estimate the length of time I will dedicate to your case and you agree to pay this estimate 3-7 days prior to my appearance in court.

Self-Pay Clients-Required Card on File

I understand and agree that if I am a self-pay client that an active and valid credit/debit card in the client's or parent/guardian's name must be placed on file. This card cannot be an FSA or HSA card. I understand that if the card on file is declined for any reason, I will need to place a new active card on file within 24 hours of the date of service. If I do not place a new active card on file, the next appointment scheduled will be cancelled until an active card is placed on file and the previous balance has been paid in full. I also understand that I will also incur on the second business day after declination and no active valid card has been placed on file, a service fee of $25, to be charged to my account. My signature on this consent authorizes Tameka L McFarland, MS, LMFT, NCC, CPLC to charge the saved card on file with Square automatically for all session fees incurred if not done so voluntarily within 30 days of termination of services or last appointment date.

EMERGENCY MEDICAL TREATMENT

I grant my authorization and consent for Tameka L McFarland, MS, LMFT, CPLC and staff (hereafter"Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the myself or the minor child client in office. Ifthe injury or illness is life threatening or in needof emergency treatment, I authorize the clinician to summon any and all professional emergency personnel to attend, arrange the transport, and treat the minor and to issue consent for any X-ray,

anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, but

is given to provide authority and power on the part of the clinician in the exercise of her best judgment upon the advice of any such medical or emergency personnel.

Contacting the Clinician Directly

I understand that the clinician will only speak to me directly in person, by phone or telehealth if there is an appointment scheduled. If there is a crisis, which is defined by a life or death situation (homicide, suicide, domestic violence), I may contact my clinician via text, email, or phone call directly. I understand that I will be billed $90 for every 30 minutes of crisis intervention services that are provided. I understand that those fees may or may not be covered by my mental health benefits and that I will be responsible for paying for those services if they are not covered. For these situations only, I understand that she will be available outside of scheduled appointment times. I understand that if I email or call her about a situation that is not a crisis situation, she has the option to return my phone call, texts, or emails at her convenience and that I may have to wait to discuss my matter at my next scheduled appointment. I understand that for crisis during or after hours, I can contact her at the following mobile phone number (252) 219-0206 or email her directly at tmcfarland@themftpro.com I further understand that if she does not contact me back within 15 minutes of my call/text/or email I have the option to call 911, visit my local emergency department orcall/text the National Suicide Prevention Lifeline at 988 for immediate assistance. I will not hold Ms. Tameka L McFarland liable for any injuries that I incur should she not be able to respond within 15 minutes because I understand and agree that I had the option to receive immediate assistance from the above specified entities.

Electronic Communication

I understand and consent to receive emails and text messages as specified when I completed my client/patient consultation demographic form using an unencrypted or encrypted email system and will not hold the clinician liable for any third-party interference/reception who is able to access information transmitted using these methods. This includes if the clinician emails me with tools and articles to refer to that will help me with achieving my therapeutic and/or life coaching goals. I consent to the use of telehealth services using the HIPAA compliant platforms "Doxy.me" as a primary or alternate method of receiving services as agreed to by the clinician and myself in other conditions. I consent to treatment under these aforementioned terms and conditions in this document.

Consent for Telehealth Services

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding
I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time. I understand that none of the telemental health sessions will be recorded or photographed. I agree not to make or allow audio or video recordings of any portion of the sessions. I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent. I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure. I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation. I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact. I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services. I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card form of payment will be established before the first session.
I understand my therapist will advise me about what telemental health platform to use and she will establish and initiate a video conference session.

Terms

Licensing
The Business promises that it holds all licenses necessary to perform the work, that such licenses are valid and effective as of the date any work is performed or services provided, and that all work performed or services provided will be done in compliance with all applicable federal, state, or local laws and regulations.

Signatures

This contract may be signed electronically or in hard copy. If signed in hard copy, it must be returned to the Business for valid record. Electronic signatures count as original for all purposes.

By typing their names as signatures below, both parties agree to the terms and provisions of this agreement.

Business signature

Owner name	Tameka L McFarland
Owner signature	*Tameka L McFarland*
Business date signed	05/04/2023

Recipient signature

Recipient name	
Recipient signature	
Recipient date signed	