Tameka L McFarland, MS, LMFT, CPLC

1135 Kildaire Farm Rd, Suite 200
Cary, NC 27511
Office: (919) 415-4720 Mobile: (252) 219-0206 Fax: (252) 557-1850
Email: tmcfarland@themftpro.com

INTAKE AND CONSENT

I. INTERNAL DATA – To be completed by Client or Parent/Guardian of Minor Child Client

Record Number: _____ **Enrollment Date:** _____

II IDENTIFYING INFORMATION

Name:_____ **DOB:**_____ **Gender:** ☐Female ☐Male ☐Other

Marital Status:_____ **SS Number:**_____

RACE: ☐African Amer. ☐Caucasian ☐Hispanic ☐Bi-Racial ☐Other:_____

ETHNICITY: ☐Not Hispanic/Latino ☐Cuban ☐Mexican ☐Puerto Rican ☐ Hispanic Other _____

Address:_____

City: _____ **State:** _____ **Zip Code:** _____

County of Residence:_____ **Home Phone:**_____

Work/other Phone:_____ **Email:**_____

Competency Status: ☐ Competent adult ☐ Incompetent adult with an appointed guardian ☐ Minor child

III. ADDITIONAL INFORMATION FOR MINORS AND INCOMPETENT ADULTS

Guardianship papers are required for incompetent adults and minors not in the custody of biological parents

Name of Legal Guardian(s):_____ **Relationship:**_____

Legal Guardian Address:

_____

Legal Guardian Phone: _____ **Email:** _____

Mother's name:_____ **Father's name:**_____

Parent's Marital status:_____

Mother's Address:_____ **City:** _____ **State:** ____ **Zip:** ____

Mother's

Email:_____

Mother's Home phone:_____ **Mother's Cell:**_____

Father's Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Email: _____

Father's Home Phone: _____ **Cell Phone:** _____

IV. FEE AGREEMENT AND INSURANCE INFORMATION

Medical Insurance Co. _____ Effective Date of Coverage :_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Number:_____ Plan Code:_____ Group #:_____

Policy Holder's Name:_____ DOB:_____

Address:_____ Relationship to Consumer: _____

Employer:_____ Phone:_____

PLEASE READ AND INITIAL EACH OF THE STATEMENTS BELOW:

_____ I hereby assign payment of insurance benefits to Tameka L McFarland, MS, LMFT, CPLC . I understand that I will be responsible for some portion of the cost of my services unless my insurance company pays 100% of the charges
billed to them. In the event that Tameka L McFarland, MS, LMFT, CPLC I understand that I am responsible for paying the fee for services and filing the insurance claim myself and that if I do not provide information necessary to file for insurance reimbursement, I will be responsible for the full charge for services rendered. I hereby authorize Tameka L McFarland, MS, LMFT, CPLC and all other parties to release information required for filing of my claim and information regarding potential eligibility for benefits. I agree to notify the office of Tameka L McFarland, MS, LMFT, CPLC of any changes in my insurance coverage and benefits.

_____ I understand I am responsible for deductibles and co-pays, as required by my insurance provider before each session begins either by cash or credit/debit card. I understand that any outstanding balance must be paid before the next scheduled appointment begins. I understand that information about my mental health diagnosis is required to be disclosed when requesting reimbursement to the clinician for the cost of services on my behalf. I agree to direct all billing and insurance coverage questions to the billing manager, Tameka L. McFarland, MS, LMFT, NCC, CPLC in writing via fax (252) 557-1850 or email – tmcfarland@themftpro.com

V.EMERGENCY INFORMATION

Emergency Contact Name: _____ **Relationship:** _____

Home Phone: _____ **Work/Cell Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Care Dr. : _____

Address: _____ **Phone:** _____

Preferred Hospital:

_____

List all known medical conditions: _____

_____

List all known allergies: _____

Current Medications and Dosage:	**Condition Treated:**

V. CONSENTS

PLEASE READ AND INITIAL EACH OF THE STATEMENTS BELOW:

_____ I request admission for evaluation, treatment or habilitation. Should staff determine that admission for services is appropriate, I consent to treatment as necessary. The alleged benefits, potential risks, and possible alternative methods of treatment have been explained to me. If the comprehensive clinical assessment indicates that I would not benefit from services available through Tameka L McFarland, MS, LMFT, CPLC, I will be referred to a more appropriate resource for assistance. I understand that I may withdraw from services at any time by notifying the above mentioned clinician's office either verbally or in writing of my decision. I understand that such notice will be documented within my EHR (Electronic Health Record).

_____ I hereby grant permission to Tameka L McFarland, MS, LMFT, CPLC and their staff to text, call, or leave voicemail if I am not available.

_____ I understand that certain medical and personal information may be contained in a confidential computerized record keeping system for reimbursement, statistical, and program planning purposes.

_____ I hereby grant permission to Tameka L McFarland, MS, LMFT, CPLC and staff to utilize text messaging services/or secured email for appointment reminders and sending and receiving correspondence (without PHI) related solely to treatment coordination or sessions/appointments.

_____ I have received a copy of the Notice of Privacy Practices and have been given the opportunity to ask questions. I understand and have been afforded the opportunity to ask questions regarding examples of when my protected health information can be released/disclosed with or without consent. I hereby authorize Tameka L McFarland, MS, LMFT, CPLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI). I understand such notification will be documented by Tameka L McFarland, MS, LMFT, CPLC.

_____ I understand that if receiving treatment in a group/couple/family setting, I am obligated to keep all information confidential and agree to refrain from disclosing any information discussed. If at any point during couples or family counseling my therapist recommends individual therapy for myself, child(ren) or my partner/spouse, I understand and agree to the confidentiality of the client/therapist relationship between myself, my child(ren), or my partner/spouse and the clinician. I further agree to withhold any and all legal liability to the clinician should she be subpoenaed to testify in court by a judge on the behalf of either myself, my child(ren) or my partner/spouse. I agree to protected confidentiality and understand that our licensed clinician, Tameka L. McFarland, MS, LMFT, NCC, CPLC will assess for interpersonal violence and lawfully is required to report the abuse and or neglect of all elderly persons and those under 18 years of age either male or female. I also understand that she may, at her recommendation request to meet with either party of an intimate relationship individually if based on the assessment results she determines a safety risk or harm to that party. I agree that abuse/neglect is defined as physical, emotional, psychological, financial, or sexual. I also understand that the clinician named above will assess for the safety of all pets in the care of the parties involved in therapy. I understand that the therapist will assess and advocate for the safety of ALL parties involved in the therapeutic process.

_____ I agree to and understand that during group/couple/family counseling, I will disclose information regarding any infidelity to my partner. I understand that this is due to the nature of possible exposure of myself or my spouse/significant other or family member to any communicable diseases, especially HIV/AIDS and other STDs so that myself and my partner/family member may receive appropriate medical care. This clause in this consent form is directly related to the No Harm Contract that applies to myself and other relevant parties in relation to the office of Tameka L McFarland, MS, LMFT, CPLC

_____ I understand that Tameka L McFarland, MS, LMFT, CPLC and their staff do not discriminate in providing care on the basis of race, ethnicity, religious, spiritual, or cultural beliefs.

_____ I agree to the fee of $70 per 45-60 minute session for life coaching services should I request or be recommended those services from Tameka L McFarland, MS, LMFT, CPLC, I understand that life coaching services are different from psychotherapy and are NOT covered by medical/mental health insurance benefits of any kind.

_____ I understand that in the event of a crisis of another client, my scheduled appointment may be cancelled without notice in order for the clinician to intervene for the safety of the client and/or other relevant parties involved.

understand that Ms. Tameka L McFarland, MS, LMFT, CPLC will call, text, or email me to reschedule the cancelled session within 48 hours of the cancellation.

_____ I understand that the clinician reserves the right to terminate services at any time and for any reason. She will provide written documentation of such decision within 7 days of termination. She will also provide a referral either verbal or written to three other licensed clinicians in the local area within a 50 mile radius.

_____ I understand that it is the professional judgement of the clinician, Tameka L McFarland, MS, LMFT, CPLC to recommend and exercise her professional rights to involuntarily commit a client to an inpatient mental health facility for the safety of the client and/or other relevant parties. I also agree and understand that she also has the professional right to recommend and refer a client verbally and in written form of a need for a psychological evaluation or psychiatric evaluation to maximize the prognosis of the client's mental health treatment.

I understand all of the statements contained within this Intake and Consent form and have provided accurate information to the best of my ability. The consents shall be valid for one year unless I decide to revoke them sooner or to the extent that action based on this consent has been taken. Additional information not outlined within this consent form will not be released to third parties unless I sign an Authorization to Release Information Form indicating my agreement with the release of protected health information.

**By signing this form I acknowledge my full consent to treatment with Tameka L McFarland, MS, LMFT, CPLC. I have been
informed of my right to refuse treatment and have discussed with staff additional reasons why services may be terminated or I may be discharged from care. I have been informed of the right to consent or to refuse treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.

_____ _____

Signature Date

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AUTHORIZATION TO RELEASE INFORMATION

RE: _____ CLIENT NUMBER: _____
(Last Name, First Name)

INSURANCE ID NUMBER: _____ DATE OF BIRTH: _____

I hereby authorize the release of specified treatment information *from* the agency/person listed below *to* and from Tameka L McFarland, MS, LMFT, CPLC for agency/person listed below for the purpose of assessment, treatment planning, referral, and coordination of services.

Name of Agency/Person and Fax Number:

_____

Please initial below indicating which documentation regarding your treatment may be released/exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

____ Reason for Referral/Screening
____ Assessments
____ Psychological/Diagnosis
____ Service Plans
____ Service Notes
____ History of Psychotropic Medication Use
____ Academic Achievement and Behavior
____ Social/Developmental History
____ Medical Information
____ Other: _____
____ Authorization to provide treatment updates/coordination of care via secure email.
____ Release of records is authorized even if records contain information related to substance abuse.
____ Release of records is authorized even if records contain information related to HIV/AIDS.

Tameka L McFarland, MS, LMFT, CPLC does not release information generated from other agencies.

I understand that the Federal Privacy Law (45 CFR Part 164) protecting Health Information may not apply to the recipient and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.

I understand the contents to be released, the need for the information, and that the information to be released is protected under State and Federal law, and cannot be re-disclosed without my further written consent as authorized by G.S. 122C-53 through G.S. 122C-56. Holistic Therapy Kneads, LLC's Notice of Privacy Practices describes circumstances where disclosure is permitted or required by state or federal laws.

I certify that this authorization is made freely, voluntarily, and without coercion. I understand that by submitting a written request to the office of Tameka L McFarland, MS, LMFT, CPLC, I may revoke this consent at any time, except to the extent that action has already been taken. Without my express revocation, this consent will automatically
expire upon satisfaction of the need for disclosure and is valid for one year from the date signed. I understand that I have the right to choose a revocation date for this consent that is less than a year by indicating the preferred date or event of expiration in the comment space provided at the bottom of this form.

_____ _____ _____ _____

Consumer/Legal Representative Date Witness/Office Staff Date

Legally Responsible Person has the authority to act on behalf of this consumer based on the following:

☐ Power of Attorney ☐ Guardianship ☐ Other: _____

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EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM

This form grants temporary authority to Tameka L McFarland, MS, LMFT, CPLC and their staff members to provide and/or arrange for medical care for an adult or minor client in the event of an emergency. Any staff member may provide or arrange for medical care where there is a minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should accompany the client or minor child client in the event of emergency relocation of the treatment program.

Client's Full Legal Name:_____ **Date of Birth:** _____

Legal Guardian's Name: _____ **Phone:** _____

Address:_____

_____

Gender: ☐ **Female** ☐ **Male**

Primary Care Physician's Name and Location of Practice:_____

Physician's Phone # (if known): (____)_____

Medical Insurance Policy Holder Name, DOB, and Policy #:

_____

Allergies to Medications:_____

Allergies (Other):_____

Please note all conditions for which the client is currently receiving treatment:

Note any other significant medical information:

AUTHORIZATION AND CONSENT – EMERGENCY MEDICAL TREATMENT

I do hereby state that I am the adult client or I have legal custody of the aforementioned minor client. 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. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, 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 Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Signed this ____ day of _____, 20___.

This authorization is effective through ___/___/____.

Parent/Legal Guardian Signature:_____

Printed Name:_____

Witness Signature:_____

Printed Name:_____

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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.

Your signature below indicates your understanding and agreement to the terms set forth above ONLY if I am subpoenaed by a judge in a court of law to appear on your behalf.

Client or Parent/Guardian's Signature: _____ Date: _____

Printed Client/Parent/Guardian's Name: _____

Tameka L McFarland, MS, LMFT, CPLC

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Cary, NC 27511

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No Harm Contract

I, _____, agree that I will not harm or hurt myself and/or others in any way.

I, _____, further agree that I will successfully contact at least one of the agencies or individuals listed in the event that I experience suicidal or homicidal thoughts or the urge to injure myself and/or others.

_____ _____

Signature of client Date

_____ _____

Signature of Parent/Guardian (client under 18yrs.) Signature of Therapist

Names of Individuals or Agencies:	Telephone Numbers:
Emergency: _____	_____
Therapist: Tameka McFarland, MS, LMFT, NCC, CPLC	(252) 219-0206
Mobile Crisis	1.800-273-TALK
Chat Text Line	741-741

Professional Disclosure Agreement

Tameka L. McFarland, MS, LMFT, CPLC

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Cary, NC 27511
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***Mobile:** (252) 219-0206*
***Fax:** (252) 557-1850*
Email: tmcfarland@themftpro.com

Objective: To serve a diversity of populations in the human service field within the area of mental health by demonstrating and providing exceptional individual, couple and systemic family psychotherapy skills

Education

- ***Capella University, Minneapolis, MN (March 2017);*** Master of Science in Marriage and Family Counseling/ Therapy; Chi Sigma Iota 2016
- ***University of North Carolina at Greensboro (May 2004): Greensboro, NC;*** Bachelor of Arts in Psychology; Minor in Human Development and Family Studies (HDFS)
- ***Rocky Mount Senior High School (June 2000): Rocky Mount, NC;*** High School Diploma

Licensure & Certification

Licensed Marriage and Family Therapist (December 2017-July 2022): NC LMFT #2185

Certified Proficient Life Coach (June 2017) – Completion of Expert Rating self-paced Life Coach Coursework

National Board Certified Counselor (May 2017-May 2022)- NCC # 830994; Achieved a passing score on the National Counselor's Exam demonstrating competency in foundational and experiential counseling skills

North Carolina Praxis Test for School Counselors (Spring 2015)- Achieved a passing score showing competency in school counseling practices

North Carolina Praxis Test for Exceptional Children and Regular Education Grades K-12 Language Arts and Math (Spring 2006 & Spring 2008) – Achieved a passing score showing competency in differentiation of instruction for students with mild to moderate learning disabilities and regular education students in the areas of Language Arts and Math (License expires 6/30/2022)

Appointment Attendance Policy:

You may go online to my personal website or call or text the mobile number to cancel, and reschedule appointments. This is extremely convenient! As a valued client, your appointment time is reserved especially for you. Text, email and voicemail reminders are sent 24-48 hours before your scheduled appointment time. You understand that it is your responsibility to make sure you have an updated cell phone or home phone number on file in our system. You understand that you may call the office, email, or text my cell phone number listed above to notify me of your absence if you choose not to access our website for scheduling. If you do not provide at least 24 hours notice of you not being able to attend your appointment, you understand that you will incur a **$50 late cancellation fee for each missed appointment** that must be paid before any other appointments are scheduled. This also applies to clients who do not provide notice and do not show for their appointments.

If 2 appointments are missed without at least 24 hours notice, you will no longer be placed on my schedule and I will terminate services immediately. I will also terminate services if you cancel later than 24 hours notice for 2 appointments consecutively. I will refer you to at least 3 other service providers in the area. You understand that my schedule fills up quickly and there is a waiting list in some cases to get an appointment with me.

Payment Responsibility

You can pay online anytime before your appointment via my TheraNest website or the Square, Inc. invoice. Co-pays are due 30 minutes before the beginning of each session . It is your responsibility to make sure that we have accurate insurance information in order to bill your services to your insurance company. If you do not have coverage at the time of service, the claim that was submitted to pay for the services you have received will be denied. The client or parent/guardian of the client will be responsible for the balance on the account. **I will not schedule clients who have a past due balance on**

their accounts and will discontinue services until your account is current or your insurance information has been confirmed as active and billable for services. This is NOT negotiable. I am responsible for all billing and will answer any billing related questions or concerns with all clients.

The Therapeutic Process

Therapy is a valuable service that I have also participated in before while going through some troubling times in my life. You understand that the process is not easy all the time and you understand the risk of it being uncomfortable during some sessions. However, it is a worthwhile and life changing process if you do the work! You understand that the therapeutic process requires a commitment from you and that change and healing in your life begins with your commitment to doing the work alongside me as your therapist and coach. You understand that therapy is not only for crisis situations that arise on occasion. It is also for the ongoing prevention and learning of tools and skills to help you manage different areas of difficulty in your life. **Remember, therapy is about you changing your own behavior. You cannot change anyone else.**

Confidentiality & Limits

Everything said in sessions is confidential unless what is said involves harm to someone else or it involves the abuse of a minor child or elderly person. You understand that I am legally a mandated reporter of any form of abuse or neglect to a minor child or elderly person and will contact the proper authorities to investigate. If you have questions, please refer back to the informed consent for treatment document.

Couples/Marriage Counseling

All couples who enter therapy together, understand that they are expected to attend therapy together unless one party decides they no longer would like to attend. If they are absent for 3 weeks of joint

therapy sessions, they will be referred to another therapist for individual counseling. **I will only see individual partners for counseling when** discussing the results of the Gottman or Prepare/Enrich assessment **to avoid ethical violations or attempted collusion of parties.** If a couple has decided to separate or divorce, I will see each party individually with the goal of helping them each adjust to their new lives apart. Afterwards, we will come back together for 1 couples counseling session to terminate services. All individual sessions are confidential as well. **If the issue of infidelity arises, I will discontinue individual counseling but not before requiring the guilty party to come clean to their partner about the affair. If they refuse to disclose the affair to the other partner, I will terminate services with all parties and refer out to 3 other therapists within a 50-mile radius. Termination will occur due to my professional no secrets policy. The no secrets policy also refers to the possible transmission of fatal or non-fatal diseases to the unknowing party and their right to medical treatment.**

Counseling, regardless of how many people attend, requires a serious commitment from all parties in order to see improvement. Ideal successful outcomes for therapy require at a minimum of 6-12 months of weekly or bi-weekly attendance and dedicated emotional and psychological work. All couples are required to take either the PREPARE/ENRICH or GOTTMAN RELATIONSHIP CHECK-UP which is an additional $50 cost NOT COVERED BY INSURANCE. You will receive a copy of your results for your records.

Parents/Guardians of Minor Children

As the parent of a minor child who is receiving therapeutic services, you understand that your consistent participation in the therapeutic process for your child is required. You understand and agree to attend the first 3 sessions with your child or without your child. Many problems that children have need to be discussed with parents only first to ensure the clinician has an accurate background and to also rule out

other factors that may be causing the child to exhibit the behaviors you as a parent are concerned about. You agree to this requirement to attend the first few therapy sessions. After those sessions, we will determine how much more parent participation is needed and would be best beneficial for your family as we proceed through the therapeutic process. Only parents/legal guardians of minor children are allowed to register their children for services in our office.

Professional Boundaries

As a professional, I am expected to uphold the standard of service for Licensed Marriage and Family Therapists in the state of NC where I am licensed. I am a fully licensed clinician in the state of North Carolina. I am expected to adhere also to ethical standards set aside by the American Association of Marriage and Family Therapists (AAMFT) which I am a dedicated member of. I am not allowed to befriend any of my clients through social media or outside of social media. I also reserve the right to refer a client out of my practice if their mental health needs surpass my professional scope of practice. I will verbally or in written format let the client know this decision. This could include referrals for a psychological or psychiatric evaluation and treatment. This referral does not necessarily mean that you as a client will not still receive concurrent treatment with me and the referred clinician. Sometimes, the coordination of services is critical to the optimal level of prognosis (outcomes) for the client. I reserve the clinical and professional right to involuntarily commit a client into a psychiatric hospital should I assess and believe based on the assessment that they are a threat of harm to themselves or anyone else. **Please remember, that my relationship with you is a professional relationship only.**

TeleHealth Services

Due to the COVID-19 Pandemic in March of 2020, I have opened my availability for telehealth appointments to clients who legally reside in the state of NC only. I am not licensed and can not treat

clients who do not have proof of residence in NC whether in person or via telehealth means. Please refer to the telehealth consent form for questions regarding these services.

Parents with Educational Concerns

I do not conduct school-based observations or evaluations for clients who are children. As a former regular education, school counselor, and special education teacher of 14 years, I am knowledgeable of and will provide you with information for whom to contact in your child's school or district to complete a social/emotional, educational, or psychological evaluation for your child. You may then fax or bring a certified copy of that observation that was completed by licensed personnel at your school to the office.

Complaints

As your therapist, it is my hope that I am a match with being able to meet the needs of you and your family. However, I understand that everyone is unique in their needs and expectations of their mental health service provider. Should you have a concern with your care, I will attempt to resolve any conflicts with you immediately. If you do not feel comfortable addressing your concerns with me or we are unable to reach a resolution, you may contact the NC MFT board if you feel that I have not done my best to resolve your complaint.

Choice of Providers

At anytime during the course of your treatment, you may terminate services. You also agree to and understand, that I, the clinician, also have the right to refuse or terminate services with you for any reason. This termination will be documented in detail in your confidential clinical records. I will gladly refer you to at least 3 other service providers in the area to assist in meeting your mental health needs. These providers will be located within a 50 mile radius of my office location.

If after reading this document you do not agree to these terms, I will refer you to 3 other therapists in the area to meet your needs.

Understanding of Professional Disclosure Agreement

My signature below indicates I have received notice from my therapist of her professional expectations for my care. I also agree to abide by and adhere to the standards set forth above.

Client/Parent Signature: _____ **Date:** _____

Client Printed Name: _____

Tameka L McFarland, MS, LMFT, CPLC

NOTICE OF PRIVACY PRACTICES

I. GENERAL PROVISIONS

Tameka L McFarland, MS, LMFT, CPLC is required by law to protect the privacy of health care information about you and that identifies you. This may be information about the care we provide to you or payment for care provided you. It may also be information about your past, present, or future health care condition. We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to health care information. We are legally required to follow the terms of this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our facilities
- Have copies of the new Notice available upon request (you may always contact the Privacy Officer listed in this notice to obtain a copy of the current Notice)

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you
- Explain your rights with respect to health care information about you
- Describe how and where you may file a privacy-related complaint

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact the Privacy Officer listed in this notice.

We use and disclose medical information about clients when needed. As a general rule, Tameka L McFarland, MS, LMFT, CPLC will not disclose healthcare information about you outside our organization without authorization (signed permission) from you or your legally responsible person/personal representative unless otherwise permitted or required by state and federal confidentiality laws. This section of our Notice explains in some detail how we may disclose medical information about you in order to provide health care, obtain payment for that health care, and operate our business efficiently.

II INFORMATION DISCLOSURE

Information may be Disclosed Under the Following Circumstances:

1. Treatment

We may disclose information about you to provide treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your care with others.

2. Payment

We may use and disclose medical information about you to obtain payment for services that you received. This means that, within the staff of Tameka L McFarland, MS, LMFT, CPLC, we may use information about you to arrange for payment (such as preparing bills and managing accounts).

3. Health care operations

We may use and disclose medical information about you in performing a variety of business activities that we call "health care operations." For example, members of your treatment team and quality improvement committee may use information in your record to assess the care and outcomes in your case. These "health care operations" activities allow us to improve the quality and effectiveness of the services we provide.

4. Persons involved in your care

We may disclose medical information about you to a relative or other person you identify if that person is involved in your care and the information is relevant to your care. If the client is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor.

5. Required by law

We will use and disclose healthcare information about you whenever we are required to do so by law. There are many state and federal laws that require us to use and disclose healthcare information. For example, state law requires us to report known or suspected child abuse or neglect to the Department of Social Services.

6. National priority uses and disclosures

When permitted by law, we may use or disclose medical information about you for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law.

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the health care system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an office of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge ordered us to do so.

- **Law enforcement:** We may disclose medical information about you to a law enforcement official for law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and national and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. Authorization

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose healthcare information about you, may later revoke (or cancel) your authorization in writing. If you would like to revoke your authorization, you may write us a letter revoking your authorization. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

III RIGHTS

Your Rights Regarding the Information About You:

1. Right to a copy of this Notice

You have a right to have a paper copy of our Notice of Privacy Practices anytime. In addition, a copy of this Notice will always be posted in our facilities. If you would like to have a copy of our Notice, ask the staff for a copy.
Reasonable accommodations shall be made for clients with special needs such as visual impairment, reading comprehension level, or non-speaking English.

2. Right of access to inspect and copy

You have the right to review and receive a copy of medical information about you that we maintain in certain groups of records. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing.
We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. If you would like a copy of the information, we will charge you a fee to cover the costs of the copy.

3. Right to have medical information amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information.
We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an accounting of disclosures we have made

You have the right to receive an accounting of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter of request.
The accounting will not include several types of disclosures, including disclosures for treatment or payment. It will also not include disclosures made prior to April 14, 2003. It will only include documentation that has been disclosed, not information shared verbally. If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting form.

5. Right to request restrictions on uses and disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and health care operations. We are not required to agree with your request. If we do agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

6. Right to request an alternative method of contact

You have the right to request to be contacted at a different location or by a different method. For example, your may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies procedures, you may file a complaint either with us or with the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with Tameka McFarland, MS, LMFT, NCC, CPLC, you may you may mail it to the following address:
NC MFT Licensure Board
1135 Kildaire Farm Road, Suite 200
Cary, NC 27511

You also may send a written complaint to the Secretary of the Department of Health and Human Services at:
Office for Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, DC 20201