Sara Irene McCartney, MA, LCMHCS #S8035
DBA ~ Disciple 4 Life, LLC
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Telephone: 910-433-9007 Fax: 910-433-2004 Cell 910.257.5083
Email: counselor.therapist4u@gmail.com
www.disciple4lifesara.com
https://doxy.me/disciple4life

CLIENT INTAKE FORM

Today's Date _____/_____/_____ **Time** _____ **Therapist: Sara I. McCartney, MA, LCMHCS**

CLIENT INFORMATION

Client's Last Name	First	Middle	Race	Marital Status (Circle One) Single / Married / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Guardian's Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Other:

Email Address:	Alternative Email Address:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )

Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Self Pay ❑ YES ❑ NO

Select Insurance Provider(s)
Authorized Number of Sessions_____

❑ Alliance ❑ BlueCrossBlueShield ❑ NCTracks ❑ UnitedBehavioraHealthcare ❑ SandHills
❑ Cigna ❑ TriCare ❑ CarolinaComplete ❑ Wellcare ❑ Magellan ❑ NewDirections ❑ Aetna

Effective Date of Policy / / Signature Authorizing Utilization of benefits for services:

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Name:_____ DOB: _____

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PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Sara I. McCartney will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____

NAME OF CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the contacting of emergency services personnel or a primary care physician in the event an emergency occurs during services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the use of telehealth services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the use of cell phones for text messaging and email for communication knowing neither are in compliance with HIPPA requirements.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

Name:_____ DOB: _____

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CLIENT INTAKE FORM
Medical / Psychiatric

Primary Care Physician(s) and Contact Information: _____

Psychiatrist(s) and Contact Information:_____

Many managed care companies require that I have interaction with client's physician(s) to coordinate care. Do you give me consent to discuss your care with the above named doctor(s) over the term of treatment with consent subject to revocation at any time to include any information regarding: psychological/psychiatric ____YES ____ NO, social ____YES ____ NO, medical (HIV/AIDS NC General Statute 130A – 143) ____YES ____ NO, Substance Abuse (42 CFR Part 2)? ____YES ____ NO

Please sign here for either answer:_____(date)_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____ Dosage/Freq_____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

4)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by:_____

Are you Compliant with taking your medication(s) ? ____ NO _____ YES

Pregnant: ____YES ____ NO Dental Problems: _____

Allergies: ____None ____Food _____Airborne Medication-specify:_____

Nutritional Needs Being Met: ___Yes ____No Explain: _____

Disabilities: ____None ____Hearing Impairment ____Visual Impairment ____Ambulation_____Other

History of Head Injury: ____YES ____NO If YES explain: _____

Have you ever been hospitalized for medical or psychiatric reasons? ____ YES ____ NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

History of Withdrawal Symptoms:

Has the client experienced these problems in the past?

☐ Sweats ☐ Hangovers ☐ Nausea ☐ Insomnia ☐ Hallucinations ☐ Seizures ☐ Shakes ☐ Irritability ☐ DT's

Has the client ever had suicidal thoughts of attempt suicide while using? ☐ Yes ☐ No

Type of Drug	How much	How often
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list: Type of Alcohol	How much	How often
_____	_____	_____

Do you smoke cigarettes Or use other forms of tobacco? (Circle One) YES NO

If yes, what kind? _____

Name:_____ DOB: _____

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Describe any important medical history, chronic ailments, or other health problems you experience:

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

_____

_____

_____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:_____

_____

What was the last year of school you completed? _____ If you did not complete high school, please explain:

_____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)_____ Year(s)_____

(2) School(s)_____ Year(s)_____

(3) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.): _____

_____

_____

Please check all information which applies to your biological parents:

MOTHER	____ living	FATHER	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

Where do your parents live? Mother _____

Father _____

Describe your relationship with your mother while growing up:_____

_____

Currently: _____

_____

Describe your relationship with your father while growing up: _____

Name:_____ DOB: _____

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_____

Currently: _____

_____

List first names and ages of brothers & sisters, including you:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse:

_____

_____

_____

Sexual/physical/emotional abuse:

_____

_____

_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT SYMPTOMS / BEHAVIORS:

Please check any of the following that describe how you have been feeling lately:

____ Fidgety/Restless ____ Panic ____ Depressed ____ Fear/Anxiety ____ Impulsive ____ Disgust/fear of contamination

____ Shame ____Preoccupation ____Resentment ____Worthless ____ Irritable ____ Confused ____ Phobia ____ Sad

____ Misunderstood ____ Hyperactive ____ Avoiding People ____ Helpless ____ High Risk Activities ____ Mood Swings

____ Intruding on Others ____ Guilt ____ Anger ____ Grief ____ School/Work Problems ____ Loneliness ____ Tearful

____ Suicidal Thoughts ____ Tantrums/Rages ____ Physical Aggression ____ Relationship Concerns ____ Verbal Aggression

____ Overwhelmed ____ Hallucinations ____ Attention Problems ____ Disorientation ____ Hopelessness ____ Jealous

____ Hurting Others ____ Memory Problems ____ Sexual Difficulties ____ Hurting Self ____ Sleeping Difficulty ___ Envious

Name:_____ DOB: _____

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Describe any other feelings or reasons you have had that brings you to counseling:_____

_____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

_____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

_____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

_____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:_____

_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:_____

_____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

_____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain:_____

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ASSESSMENT OF STRENGTHS AND WEAKNESSES

Assessment Area	Identified Strenghts	Identified Weaknessess
Biological		
Psychological		
Family		
Social		
Developmental		
Enviromental		

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

CONSUMER NEEDS / REQUESTS / GOALS:

Recommendations for additional assessments, services, support, or treatment:

_____

Client Preferences of needs, requests, and goals: (i.e., what things are most important to you, what are your hopes and wishes, what things do you value most, when you look into the future, what do you most want, etc.)

_____

_____

I/my family participated and provided information necessary to complete the assessment. I understand that this information will be used to guide further treatment plans and services recommendations. I also understand that I have a right to a copy of the treatment plan and can request a copy of the treatment plan at any time.

X _____ _____ _____

Signature of person Receiving Service Relation to Person Receiving Service Date

Legally Responsible Party

DANGEROUSNESS TO SELF OR OTHERS: (include reasons client is OR is not dangerous. Document Name, Address, Phone # and Location of intended victims when available; describe Ideation / Plan /Intent; document staffing and mandatory reporting requirements, etc.)

_____

_____

_____

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MENTAL STATUS EXAM: **X** = Present; **Hx**= History; **ND**= Not Determined

	NOT PRESENT	SLIGHT OR OCCAS.	MARKED OR REPEATED
APPEARANCE			
1. Physically unkempt, unclean			
2. Clothing disheveled, dirty			
3. Clothing atypical, unusual bizarre			
4. Unsusual physical characteristics			
BEHAVIOR			
Posture			
5. Slumped			
6. Rigid, tense			
7. Atypical, inappropiate			
Facial Expression, Suggests			
8. Anxiety, fear,apprehension			
9. Depression, sadness			
10. Anger, hostility			
11. Decreased variability of expresion			
12. Bizarreness, inappropriateness			
General Body Movements			
13. Accelerated, increased speed			
14. Decreased, slowed			
15. Atypical, peculiar,inappropiate			
16. Restlessness, fidgety			
Amplitude and Quality of Speech			
17. Increased, loud			
18. Decreased, slowed			
19. Atypical quality, slurring, stammer			
Clinical-Patient Relationship			
20. Domineering			
21. Submissive, overly compliant			
22. Provocative			
23. Suspicious			
24. Uncooperative			
FEELING (AFFECTED AND MOOD)			
25. Inapropiate to thought content			
26. Increased liability of affects			
PREDOMINANT MOOD IS			
27. Blunted, absent unvaryng			
28. Euphoria, elation			

	NOT PRESENT	SLIGHT OR OCCAS.	MARKED OR REPEATED
PERCEPTION			
32. Illusions			
33. Auditory hallucinations			
34.Visual hallucinations			
35. Other type of hallucinations			
THINKING			
Intelectual Functioning			
36. Imparied level of consciousnes			
37. Imparied attention span			
38. Imparied abstract thinking			
39. Imparied intelligence			
Orientation			
41. Disoriented to person			
42. Disoriented to place			
43. Disoriented to time			
Insight			
44. Difficulty in acknowleding the presence of psychological problems			
45. Mostly blames others or circumstances for problems			
Judgment			
46.Impaired ability to manage daily living activities			
47. Imparied ability to make reasonable life decisions			
Memory			
48. Imparied immediate recall			
49. Imparied recent memory			
50. Imparied remote memory			
Thought Content			
51. Obsessions			
52. Compulsions			
53. Phobias			
54. Derealization depersonalization			
55. Delusions			
56. Ideas of reference			
57. Ideas of influence			
Stream of Thoughts (manifested by speech)			
58. Associational disturbance			
59. Thought flow decreased, slowed			
60. Thought flow increased			

DSM Diagnosis_____

Sara I. McCartney, MA, LCMHCS Date

Name:_____ DOB: _____

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Professional Disclosure Statement

Welcome to your therapy experience. My name is Sara McCartney and I am a Master's level Therapist. I completed an intensive course of study in Marriage and Family Therapy at Liberty University in 2009. I have 12 years of couple, individual, and family counseling experience working with a diverse population at all ages focusing on affair recovery, the grief process, relational issues, addictive behaviors, anxiety, depression, PTSD, RAD, ADHD, personality disorders, adjustment disorders, pain management, and developmental disorders. I received my North Carolina license #S8035 as a Licensed Clinical Mental Health Counselor Supervisor on 4/4/2019 and my North Carolina license #8035 as a Licensed Clinical Mental Health Counselor on 3/2/12. My Licensed Professional Counselor Associate Number is A8035 (issued 6/11/2010). This agreement contains important information about my professional services and business policies. Please read this information carefully and sign it. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless there are obligations imposed on me.

The Counseling Process

My approach to therapy is client centered and systems based. This approach implies that you, as a client, are your own expert and capable of processing your own emotions and discovering your own solutions to your problems that can alter the interpersonal and intrapersonal relationships that you have in life. You should be aware that while counseling interventions offer potential benefits, they also present possible risks, such as uncovering painful or uncomfortable emotions of shame, sadness, guilt, anxiety, anger, disgust, envy, or jealousy as you discuss aspects of your life. In addition, as you grow as a result of insight gained, you may experience feelings of discomfort until you adapt and adjust to these changes. I provide a safe, supportive environment that helps you to facilitate your expression of emotions without judgment or criticism. I utilize Reality, Imago Relationship, Dialectical Behavioral, Rational Emotive, Transactional Analysis, Psychoanalytical, and Cognitive Behavioral techniques. Personal growth is dependent on many factors including your motivation and willingness to change. Therefore, I make no guarantees about the outcome of your counseling. I strive to be multi-culturally diverse and choose to adhere to an open frame of mind and to refrain from using preconceived notions of who you are as a person. Please note that as a Christian woman, my personal beliefs my be shared to assist us in your journey. Diagnosis becomes a permanent part of a client's record; therefore, I prefer to discuss such labeling with clientele and to abstain from being an HMO provider or billing insurance companies. However, I do and will utilize third party payments to supplement financial resources. In doing so, it may be necessary to release information for audit purposes from the funding source. You have a right and may request a copy of your treatment plan. In the event of a medical emergency, please go to the nearest Emergency Room or call our Community Mental Health at Cape Fear Valley at 910-615-3333 for assistance. In the event that I am not available to provide services, Maria D. Marquez, MA, LMFT will provide emergency, confidential services. She can be reached at: 910-502-3225. I will contact you regarding schedule changes and referrals. I ask the same of you. If for any reason your attendance record reflects three missed appointments or late cancellations, I will cancel all upcoming appointments for your services until such time as you are able to commit to the therapeutic process. Office hours are from 9 am to 4 pm Monday through Friday with text messages, calls, and emails welcome 24-hours a day. A response will occur within 24 hours during the work week and within 72 hours over the weekend.

Confidentiality

My relationship with you as a therapist affords us full confidential rights. I will not share information with another outside my office or within consultation lines with other professionals unless:

- You direct me in writing to tell someone else something and I agree to do so
- I believe there is a real and potential danger to you or someone else
- I suspect abuse or neglect of a child or adult as defined by North Carolina law
- I have been ordered by a court to reveal information

I communicate this rule of confidentiality at the beginning of my first session with everyone and encourage clients to share important information with not only me but with other significant people in their lives. However, I explicitly request no recording devices to be utilized without written permission. Upon request, a copy of the Code of Ethics Statement is available to you.

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Counseling Sessions

Counseling begins with an intake evaluation session, which lasts for approximately one and a half hours. During this time, I gather information about you and we decide if I am the best person to meet your needs. If we agree to continue our counseling relationship, I usually schedule one session per week. The scheduling and length of the session will depend on your needs, but will typically last for 60 minutes. In some cases, a child can attend a session separate from their parent or guardian. I ask that adults be responsible for their personal items as well as those belonging to their children. I also ask that adults return twenty minutes prior to the end of a session time.

Professional Fees

Fees charged per session for counseling services are as follows:

Intake session	$185
One 60 minute session in person or via telehealth	$145
Group counseling session	$ 60
Family counseling session	$140
In between consultation fee per minute	$ 1

Other services include report writing, telephone conversations, consulting with other professionals (at your request), and time spent performing any other advocate services you request of me. I prorate the charge for these services based on the hourly rate of **$85.** These charges are not billable to an insurance company and will be due prior to the next appointment. If you become involved in legal proceedings that require my participation, you will pay for all of my professional time, including preparation and transportation costs even if I receive a call to testify by another party. Because of the difficulty of legal involvement, I charge **$150** per hour for preparations and attendance at any legal proceeding. Fees are collected at the beginning time of the session. Payment is accepted in cash, by check, or credit card. Please be advised there is a 3.7% up-charge for credit card usage. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, a monthly service charge of **2%** can be assessed against any outstanding balance. I have the option of using legal means to secure the payment on past due accounts. This may require me to disclose otherwise confidential information. Once a session is scheduled, you will be expected to pay for it unless you provide **48 business hours advance notice** of cancellation. ***Company policy allows for a $30.00 no show or late cancellation fee with removal from the calendar after 3 episodes of no shows or late cancellations over the period of services.***

If you wish to register a complaint about my professionalism, please contact me directly. I will address any issue that may arise within 5 business days. If we are unable to resolve the issue, you may contact:

North Carolina Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone (844) 622-3572 or (336) 217-6007

Informed Consent Form

I have read the Professional Disclosure Statement and I understand it. I agree that this contract will be in effect for duration of services provided and will no longer be in effect at the point of termination of services. Consent is subject to revocation at any time except to the extent that action has been taken to include use of cell phone and email. Services can be terminated by either party involved. I agree to abide by the policies and procedures within the Professional Disclosure Statement. I agree that I understand that information may have to be released for audit purposes to a funding source and that I may obtain a copy of my treatment plan by simply requesting a copy.

_____ _____
Client or client's legal guardian Date

_____ _____
Client or client's legal guardian Date

_____ _____
Sara I. McCartney, MA, LCMHCS Date

Name:_____ DOB: _____

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CONSENT TO TELEHEALTH THERAPY

This document is intended to inform you of the benefits, risks and alternatives associated with telehealth therapy services. Your understanding of telehealth therapy is important prior to participation. Please carefully review the information below.

WHAT IS TELEHEALTH THERAPY?

"Telehealth Therapy" is a method for providing behavioral health services, including psychotherapy, using an interactive telecommunications system (e.g., the internet or telephone) by a practitioner who is licensed under state law to provide such behavioral health services to a patient in a remote location. Telehealth Therapy uses electronic communications to enable a patient to share information with a healthcare practitioner to allow him or her to provide care and treatment in accordance with the practitioner's scope of practice.

POTENTIAL BENEFITS

Telehealth Therapy provides improved access to behavioral healthcare services and time flexibility, and increased patient access to experts who may not be available for a face-to-face consultation. Telehealth Therapy also allows for efficient and prompt evaluations, consultations, diagnoses, and treatment, leading to improved access to healthcare.

Psychotherapy has been shown to have numerous benefits for individuals. Specifically, therapy often leads to a reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. However, there are no guarantees about the results or outcomes of therapy and its process.

POTENTIAL RISKS

Telehealth Therapy offers an efficient way for practitioners and patients to communicate. However, there are potential risks associated with the use of telehealth services, including without limitation:

- Delayed care due to telecommunication equipment failures or information transmission errors (e.g., poor image quality);
- The possibility that the transmission of your health information could be disrupted or distorted by technical failures;
- Risks related to a patient withholding key medical information or records; or
- Unauthorized access of protected health information (PHI) because of cyber security or other security breaches.

Psychotherapy also has its own associated risks, which may include, but are not limited to, experiencing uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness and helplessness. The process of psychotherapy often requires discussing unpleasant aspects of your life. Making changes in your life can be disruptive to the relationships you already have. It is important to assess all of the risks prior to proceeding with Telehealth Therapy.

DO I HAVE TO USE TELEHEALTH?

Use of Telehealth Therapy is voluntary and not required. You may always seek traditional, face-to-face healthcare as an alternative to Telehealth Therapy (e.g., face-to-face consultations with, or examinations by, a care provider).

INDEMNIFICATION

You agree to indemnify and hold harmless Sara I. McCartney and Disciple 4 Life, LLC from and against any and all loss, damage, expense, liability, claims, or demands brought by any party whatsoever, arising out of or related to any failure of technology or equipment in connection with the provision of Telehealth Therapy, whether or not any such loss, damage, expense, liability, claim, or demand arises from or relates to Sara I. McCartney and Disciple 4 Life, LLC negligence.

ACKNOWLEDGEMENT

By signing this form, you acknowledge that you have read this Consent and understand the risks, benefits, and alternatives of participating in Telehealth Therapy and have been given ample opportunity to ask questions which have been answered to your satisfaction. You further acknowledge and understand that: you will need to provide a full and accurate medical history, including any pre-existing health conditions, so that your practitioner can determine a treatment plan. Your Telehealth Therapy practitioner will determine whether Telehealth Therapy is appropriate for you based on your specific condition and needs. Results are not guaranteed, and you may or may not benefit from the Telehealth Therapy services.

Name:_____ DOB: _____

Sara Irene McCartney, MA, LCMHCS #S8035
DBA ~ Disciple 4 Life, LLC
Fayetteville NC, 28314
Telephone: 910-433-9007 Fax: 910-433-2004 Cell 910.257.5083
Email: counselor.therapist4u@gmail.com
www.disciple4lifesara.com
https://doxy.me/disciple4life

You will be informed of any late/no show charges associated with the Telehealth Therapy services prior to incurring any charges and you agree that you are responsible for paying the full amount of the agreed upon fees associated with no shows/late cancels of Telehealth Therapy appointments.
You may not submit a claim to Medicare, Medicaid, any other federal payor, or any state or private insurer regarding the Telehealth Therapy services rendered to you.

CONSENT TO USE THE TELEHEALTH Doxy.Me
Sara McCartney uses telehealth technology by Doxy.me.com, allowing Telehealth Therapy practitioners to conduct telehealth videoconferencing appointments. By signing this document, I acknowledge:

1. Telehealth by Doxy.Me and Sara McCartney is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my Telehealth Therapy practitioner and I may be in direct, virtual contact, Sara McCartney, LCMHCS does not provide any medical or behavioral health services or advice including, but not limited to, emergency or urgent healthcare services.
3. To maintain confidentiality, I will not share my telehealth appointment links with anyone unauthorized to attend the appointment.

THIS SERVES AS THE CONSENT TO TELEHEALTH FOR:

_____
Print Client name

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

I have read, understood and agree to the items contained in this document.

_____ _____
Client or client's legal guardian Date

Name:_____ DOB: _____

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Consumer Rights Information

In the state of North Carolina, basic human rights are defined to be the right to dignity, privacy and humane care. In addition to these basic human rights, when you are receiving publicly funded MH/IDD/SA services, you have the right to:

- Privacy and the expectation that your personal information will be kept confidential;
- Review your medical record;
- Receive care in the least restrictive environment suitable to meet your needs;
- Be informed in advance of potential risks and benefits of treatment or habilitation services, and to consent to or refuse these services without threat or termination of services;
- Participate in the development of an individualized, person-centered treatment or service plan
- Be free from mental and physical abuse, neglect and exploitation;
- Be free from unwarranted invasion of privacy;
- Be free from the threat or fear of unwarranted suspension or expulsion from services;
- Fill out an Advanced Directive, which describes how you want to be cared for if you are ever unable to decide or speak for yourself;
- Access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability
- File a complaint or grievance.

Please bring any concerns to my attention so that I may work with you to resolve them. I will respond to any grievances within 5 business days. But if you have concerns that we cannot resolve together, you may file a grievance with the offices below:

Advocacy & Customer Service Section - Division of MH/DD/SAS
3009 Mail Service Center Raleigh, NC 27699-3009
919-715-3197 OR 800-662-7030
www.dhhs.gov/mhddsas

Disability Rights North Carolina
2626 Glenwood Avenue, Suite 550 Raleigh, NC 27608
877-235-4210 OR 919-856-2195
www.disabilityrightsnc.org

NC Board of Licensed Clinical Mental Health Counselors
P.O. Box 77819
Greensboro, NC 27417
Phone (844) 622-3572 or (336)217-6007

Name:_____ DOB: _____