Life in Balance Therapeutic Healing, LLC.

2180 A1A S - Suite 102 – Saint Augustine, FL 32080
Phone: 904.864.6077 Email: info@sarahquigglmhc.com Website: www.sarahquigglmhc.com

Rights & Responsibilities

Welcome to Life in Balance Therapeutic Healing, LLC. also known as Sarah Quigg, LMHC. We are honored that you've chosen this practice. Life in Balance Therapeutic Healing and its staff are known for their professionalism, incredible services and caring and respectful attitude towards their patients. The practice was designed to provide the best services and develop ties to the community to ensure an excellent working relationship with its patients.
We extend this courtesy to you and delineate our policies and other information for promoting a smooth working relationship. Should you have any questions regarding any of the contents put forth below, please do not hesitate to ask your therapist for clarification.

Contact Info: 2180 A1A S
Suite 102
Saint Augustine, FL 32080
Phone: (904) 864.6077

What is Expected of You:

- It is expected that you will arrive on time for your sessions, and that you will give **forty-eight (48) hours notice** to your service provider in the event that you need to cancel or reschedule an appointment. When your provider does not receive forty-eight hours notice, you will be charged **a regular session for your Late Cancellation**.
- **No-show fees** are charged for appointments broken at the **rate of a regular session**. - **Fees are increased** on an annual basis at the beginning of each year.
- **Payment is due at the time of service**. We accept cash, credit and checks as forms of payment for services and products. Credit transactions are a 6.00 fee. When special circumstances arise that make payment difficult, please discuss them with your provider before they become a problem. **You are required to have a credit card on file** to expedite payment of open balances.
- We reserve the right to send **Overdue Balances of more than 90 days,** where payment arrangements have not been agreed upon, **to our *Contracted Collection Service*** for resolution. In most collection situations, the extent of your information released includes your name, the nature of services provided and the amount due.
- **If you are a couple**, you are **both responsible for the fees**. Should you break up and have a balance with us, you will each be responsible for half of any remaining fees due.

Therapeutic sessions generally run 45 minutes in length. If we are able to extend the sessions, they will be charged a **prorated fee.** For **consultations on the phone or via email** that involve therapeutic issues other than obtaining and canceling appointments, unless otherwise specified will also be billed. Sessions are scheduled on a weekly basis unless it is otherwise contracted or you are in the "closure" process.

- Services last as long as you and your provider agree are necessary.
- **Honesty, openness, active participation and willingness to change are required** for the services to be effective.
- **Completion of Homework Assignments and other tasks** as discussed and decided in session are an important part of treatment. It is highly recommended you comply with the requests in order for services to be effective. **This also applies to additional referrals** made as deemed necessary (i.e., individual therapy, substance abuse treatment, EMDR, Psychologist, etc.)

Your Rights:

- You have the right to ask questions about any procedure or intervention used during service provision.

- You have the right to decide NOT to receive services from our practice and may ask for a referral to another qualified professional whose services you might prefer.

- You have the right to end services at any time without any moral, legal, or financial obligations other than those already accrued and agreed upon.

- One of your most important rights involves **confidentiality**: Within certain limits, information revealed by you during service provision will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. At times, service provision will involve the participation of more than one family member and / or significant persons and your provider does NOT guarantee confidentiality among participants engaged in the service provision.

- You should be aware that there are several situations in which your provider is **required by law** to reveal information obtained during provision of services to other persons or agencies WITHOUT YOUR PERMISSION. Also, your provider is NOT required to inform you of their actions in this regard. These situations are as follow:

- If you threaten bodily harm or death to another person, your provider is required by law to inform the law enforcement agencies.
- If you threaten bodily harm or death to yourself, your provider will inform law enforcement agencies and others (such as spouse / partner, emergency contact person, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
- If a court of law issues a legitimate subpoena, your provider is required by law to provide the information described in the subpoena.
- If you reveal information relative to child or elder abuse and / or neglect, your provider is required by law to report this to the appropriate authorities.
- If you are in treatment or being assessed by order of a court of law, the results of the treatment or evaluation ordered must be revealed to the court.

Limitations of the service provision contract:

- Providers are not physicians and cannot prescribe medication or give recommendations about physical problems. Nevertheless, depending on the nature of the presenting concerns, providers might require clients to consult with a physician before proceeding with treatment.

- Providers cannot guarantee that each person's goals in therapy will be met completely.

- Seeing to resolve issues between family members and other persons can lead to discomfort, as well as relationship changes that may be originally intended.

Supervision and Professional Involvement:

Life in Balance Therapeutic Healing, LLC. is concerned with providing the best services possible. All information is confidential and is only utilized in supervision, or other professional endeavors (while maintaining anonymity).

Emergency Policy:

In the event of a clinical emergency, call 911 or proceed to an emergency room for immediate intervention. You may give the attendant your provider's contact information and also advise your provider of the situation by the next business day. Please note that your emergency contact person may be contacted if their assistance is needed.

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Rights & Responsibilities

Patient Name: ____

Consents, Agreements and Disclosures:
I. As a patient of Life in Balance Therapeutic Healing, LLC. (Sarah Quigg LMHC) I understand my rights and responsibilities and consent to be the recipient of its services. I have received a copy of the client's *"Rights and Responsibilities."* Parent signature is required for children under 18 years of age.

II. Emergency Contact Information:

Name:____

Relationship:___________________________ Phone Number(s):___________________________

III. I give consent for Life in Balance Therapeutic Healing, LLC. (Sarah Quigg, LMHC) to send my referrer a Thank You Letter for their referral. I was referred by (please provide their name, mailing address, email address, phone number and affiliation if any):
Name:_____________________________ Relationship:_____________________
Phone Number(s):____
Full Address: ____

IV. Please note which ones apply to each of you by marking them with a P-past or C-current:

Patient: P / C substance use; P / C sexual and physical abuse; P / C sexual, P / C money, and P / C health issues; P / C anger, P / C depression, P / C anxiety; P / C obsessions; P / C suicidal thoughts; P / C infidelity; others: ____

V. Add me to your Newsletter list: Yes ______ No ______

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*If client is under 18 years of age custodian signature(s) are required noting relationship to client and title as necessary

Patient Signature: ___________________________________ Date: ____________________

Time: ____________________

Provider Signature: ___________________________________ Date: ____________________

Time: ____________________
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