Dream Catchers
THERAPY PRACTICE

Registration Information

Dream Catchers Well-Being, LLC
15350 Commerce Drive North, Suite 204, Dearborn, MI 48120
Phone 313-203-2077 // Fax 313-203-2081

Client Information

Date of Initial Contact: _____

Preferred Name: _____

Full Legal Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

It's OK to communicate with me or leave messages/voicemails at the following (Circle or complete):
Address Home Phone Work Phone Cell Phone Email
Special considerations for name and gender pronoun to use in communications: _____

Relationship Orientation/Marital Status (Circle):
Single Married Partnered Polyamorous Open/Swing Monogamous Separated Divorced Widow

Sex Indicated on Insurance (Circle):
Male Female

Gender Identity (Circle or complete):
Female Male Gender Queer Transgender Self-defined: _____

Gender Pronoun (Circle or complete):
He/Him/His She/Her/Hers Ze/Hir/Hirs They/Them/Theirs Self-defined: _____

If Minor, Guardian Name: _____

Relationship to Client: _____ Phone Number: _____

Emergency Contact Name: _____

Relationship to Client: _____ Phone Number: _____

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Occupation: _____

Current Medication(s): _____

Allergy(ies): _____

Referral Source (If any): _____

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Insurance Information

Primary Insurance: _____

Policy Number: _____ Group: _____

Subscriber's Name: _____

Relationship to Client: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dream Catchers Well-Being, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions. I understand the benefits quoted to DC Well-Being by my insurance company are not a guarantee of my benefits.

Sign

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian, or Personal Representative* Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____

_____

Insurance Verification (To be completed by therapist)

Mental Health Coverage: In Net Out Net Max Per Year: _____

Master Medical: Yes No Co-pay Amount: _____

Deductible: Yes No Additional Visits: _____

Amount Met to Date: _____

Dream Catchers
THERAPY PRACTICE

Consent and Authorization for Services Receipt and Acknowledgment

Dream Catchers Well-Being, LLC
15350 Commerce Drive North, Suite 204, Dearborn, MI 48120
Phone 313-203-2077 // Fax 313-203-2081

Patient/Client Name: _____

Social Security Number: _____ Date of Birth: _____

I, the above named client or his/her legal, custodial parent, or legal guardian acknowledge that I am voluntarily authorizing treatment for myself, or my child/ward from a therapist at the Dream Catchers Well-being, LLC practice. I have been informed of the purposes of the treatment, the services which may be provided, and any attendant risks, consequences, and/or benefits.

I have read, understand, and agree to the Dream Catchers Well-Being, LLC Consent and Authorization for Services. I have discussed these policies with my therapist if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies to take with me if desired.

I hereby authorize my therapist to release to my insurance company any information acquired in the course of therapy.

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by or on account of this client. I have read and/or received a copy of the privacy policy.

Initial Interview (Intake): $160 Sliding Scale
Family: $120 Sliding Scale
Individual: $80 Sliding Scale

Sign

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian, or Personal Representative* Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____

_____

☐ Patient/Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date

(Please return completed form to therapist)

Dream Catchers
THERAPY PRACTICE

Notice of Privacy Practices Receipt and Acknowledgment

Dream Catchers Well-Being, LLC
15350 Commerce Drive North, Suite 204, Dearborn, MI 48120
Phone 313-203-2077 // Fax 313-203-2081

Patient/Client Name: _____

Social Security Number: _____ Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Dream Catchers Well-Being, LLC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dream Catchers Well-Being, LLC at 313.203.2077 or in writing to: 15350 N. Commerce Drive, Suite 204, Dearborn, MI 48120.

Sign

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian, or Personal Representative* Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____

_____

☐ Patient/Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date

(Please return completed form to therapist)