Consent and Authorization for Services

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

I understand the following:

1) Services will be provided by appropriate professional personnel.
2) I may contact my therapist as the need arises at the telephone number or address provided to me. If the clinician is unavailable, I have the opportunity to leave a message and will in most cases receive a return call within 24 hours. If it is a crisis, I understand that it is my responsibility to call 9-1-1 or go to the nearest emergency room.
3) Successful termination of treatment is determined when the therapist and the client agree that the treatment goals have been substantially met.
4) There are fees for the services rendered. I have been informed of those charges and that I am responsible for those charges.
   - If I am entitled to healthcare insurance payments for services received, my therapist may assist me, but assumes no responsibility for collecting such insurance payments.
   - If the outstanding balance on my account exceeds $200.00, services may be canceled until the balance is less than that amount. If this is to occur, my therapist will inform me of this no less than 24 hours before the next scheduled appointment.

Rights Related to Mental Health and Substance Abuse Services

The right:

- To ask questions about any aspect of the therapy process
- To discuss your difficulties and barriers to well-being and be open to change
- To be served without discrimination as to age, sex, race, creed, color, or national origin as long as persons receiving services meet the admission criteria for indicated services regardless of the source(s) of financial support
- To all rights guaranteed by state and federal law
- To be informed of his/her rights in a language he/she and, as appropriate, his/her family understands
- To be treated without neglect or abuse and with respect and dignity regarding personal values and beliefs
- To be informed of rules and regulations regarding conduct
- To an investigation of complaints
- To obtain a copy of his/her case record
- To refuse to be a part of any research project
- To confidentiality, except as required by law
- To appropriate care, to be notified if any indicated services cannot be provided by the therapist, to be notified of other resources, if any, might be available
- To have his/her case record made available upon properly executed written authorization

- To refuse any procedure, treatment, or medication (such refusal on its own shall not be grounds for dismissal from services)
- To participate in and/or, as appropriate, have family participate in the development of an individualized plan of treatment and services, and in decisions regarding care and services
- To participate in the consideration of ethical issues arising in the providing of care and services
- To periodic review of his/her plan of treatment to determine progress in treatment

Responsibilities

I understand and acknowledge that persons receiving services have certain responsibilities including:

- To develop a plan of treatment
- To sign forms (when in my or my dependent's best interest) for the release of information pertaining to me or my dependent
- To suggest changes for the improvement of services, when appropriate
- To comply with the provisions of this Consent and Authorization of Services
- To carry out the provisions of my Treatment Plan

Confidentiality

No information, written or verbal, concerning the person(s) receiving services may be released or requested without a dated, signed, and witnessed statement made by the person receiving services or, as appropriate, by his/her legal, custodial parent(s), or legal guardian EXCEPT:

- In the case of a medical emergency
- According to state law, certain communicable diseases must be reported to the Michigan Department of Community Health
- If there is suspected child abuse or neglect and/or elder abuse or neglect that must be reported to either the Department of Social Services or the police department
- If there is a legitimate threat to harm another person or the community, the program must notify that person and may notify the police department of such intended action

The confidentiality of the records of persons being treated or having been treated for alcohol and/or other drug problems are protected by Federal Law and regulations. Generally, a therapist cannot speak of an individual's involvement in therapy to someone outside of the program UNLESS:

- The person receiving services or, as appropriate, his/her parent(s) or guardian consents in writing
- The disclosure is allowed by a court order
- The disclosure is made to qualified personnel for research, audit, or program evaluation
- The disclosure is made to medical personnel in the event of medical emergency

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threats to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Discharge / Termination

1) I understand that I may be discharged from services for the following reasons:
   - I or my dependent completes the planned course of treatment with an acceptable degree of success
   - I choose to terminate
   - The therapist feels that termination is the most reasonable option, given the particular response to treatment
   - Other circumstances make it necessary to discontinue treatment due to hardships or impracticality (e.g. job transfer)
   - Services cannot be provided in a professional and ethical manner, and in compliance with the standards of all regulatory bodies
   - I or my dependent fails to maintain contact with the therapist for a period of more than 30 days (for substance abuse services)
   - I or my dependent fails to comply with the provisions or this Consent and Authorization for Services
   - I or my dependent violates one of the rules which identifies that to do so will result in discharge

2) I have reviewed the following program rules, and agree to abide by them:
   - Possession and consumption of substances, including alcohol and non-prescription medications, are prohibited on premises. Continued use of mood altering substances may result in discharge from the program.
   - Smoking is not permitted on the premises.
   - Clients are required to refrain from disorderly conduct in the office. Physical and verbal abuse will result in discharge from therapy.
   - Deliberate deception and manipulation may be interpreted to be a lack of investment in treatment and may result in discharge from the therapy.
   - Clients are to inform their primary clinicians and the consulting physician of any and all medications they are taking.

Dream Catchers
THERAPY PRACTICE

Consent and Authorization for Services

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

Appointments

- All therapy sessions are by appointment and may be scheduled at the end of your appointment or by contacting your therapist directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment.
- The usual length of a session is 50 minutes.
- If you need to cancel/reschedule please provide notice of at least 24 hours. Late cancellations may result in the client being charged for the visit.

Fees

- The client portion (co-pay) is expected at the time of service in the form of cash or personal check.
- The therapist will bill your insurance for services provided.
- Clients without insurance coverage must discuss cost of sessions previous to beginning therapy. Payment is due in full at the beginning of each session.
- Except in the case of minors or when other arrangements are made, the person receiving therapy services is responsible for payment.

Authorizations to Communicate

1) I hereby authorize my therapist to communicate with my health insurance company and/or its agents regarding coverage which may be applicable to services received by myself or my dependent. I further authorize the therapist to release information to my insurance company or its designated agents about services rendered and to forward statements of charges and payments, as appropriate, to my health insurance company, its agents, to my home, or to the program.
2) I authorize my therapist to contact me by telephone or mail and/or to contact any resources to which I have been referred. Follow-up contacts will seek information regarding my condition and activities.

***** Emergencies

Voicemails left for the therapist are checked on a daily basis. Upon your request a call will be returned within 24 hours. **If you are experiencing a crisis situation you should call 9-1-1 or go to your nearest emergency room.**