

DREAM THERAPIES

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Client's Authorization for Emergency Medical Treatment

Please Print Clearly

Client's name: _____ Date of Birth: _____ Phone: _____
Address: _____
Physician's Name: _____ Medical Facility: _____
Health Insurance Co: _____ Policy #: _____
Allergies to medications? _____
Current medications: _____

In the event of an emergency, contact:

Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving serviced, or while being on the property of the agency, and the above can not be reached, I authorize **Dream Therapies** to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. **This provision will only be invoked if the person above is unable to be reached.**

Date: _____ Consent signature: _____

Client, Parent, or Legal Guardian signed in the presence
of Dream Therapies Staff.

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the even emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Non consent Signature: _____

Client, Parent or Legal Guardian Signed in the presence
of Dream Therapies Staff.

A copy of the completed client history should be attached to this form.