Discovery Therapeutic Services (DTS), PLLC is a private psychotherapy practice with a specialization in treating primarily trauma-related mental illnesses. Many people who experience depression, anxiety, emotional or relational issues often have a history of untreated trauma. DTS strives to help clients overcome the negative impact that trauma has had in their lives through psychoeducation and evidence-based practices designed to facilitate mental, emotional and spiritual healing. For psychotherapy to be successful, it requires your active participation, honesty, and openness. It also means that your thoughts, behaviors, assumptions and responses may be challenged, which in turn, may bring up uncomfortable feelings and reactions, such as anger, sadness, fear and anxiety. This is a normal response to working through unresolved life experiences in the therapeutic process, and the other side of that working through results in a reduction in symptoms, better feelings and choices, and a general sense of wellbeing.

Consent for Treatment

Fees for Service: Agreed upon fee $_____(60 mins) $ _____ (90 mins)

Payment is due at the beginning of each session. Regular sessions may run shorter for youth depending on their age and attention limits.

Additional Fees for Services assessed according to your hourly rate:
Extended appointments
Telephone calls or email responses lasting longer than 5 minutes
Consultation with another paid professional (with your prior approval)
Court appearances and preparation for court appearances (additionally, if subpoenaed to appear in court, mileage at .55/mile and parking fees incurred will be charged to the client)
Professional correspondence to or about a client
*Initials:*_____

Late Cancellation / No Show Policy:
_____ The full fee will be charged for not appearing at your scheduled appointment time or failing to notify at least 24 hours in advance of a cancellation. I agree to provide credit card information, which DTS will keep on file, to charge for late cancellations/no shows. If there are three consecutive no-shows and/or

cancelations within 24 hours, I understand that appointment times may be offered based on availability or that Discovery Therapeutic Services may decide to terminate treatment. *Initials:*_____

Crisis Information / Contacting Therapist
Discovery Therapeutic Services does not provide an answering service for crisis intervention outside of office hours. Instead, we give crisis information to our clients at the beginning of treatment. In the event of a crisis, *please dial 911 or go directly to the Emergency Room for assistance*. If you are in crisis during a session, an immediate plan to keep you safe will be created.

You may call or email at any time and may leave a voicemail message or email. Calls/emails will be returned during Discovery Therapeutic Services' operating hours. Urgent messages will be returned within 24 hours. *Initials:*_____

Confidentiality of email, cell phone, texts and faxes
With your permission, which includes verbal permission, your psychotherapist may communicate with you via cell phone, text, and e-mail. These means of communication is not 100% secure. If this is a concern to you, please be as brief and discrete as possible when sending an e-mail, texting, or leaving a voicemail. *Initials:*_____

Teletherapy
Teletherapy and virtual/online therapy refer to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. I will make every effort to avoid distractions while engaging in teletherapy. I understand there is potential for other people to overhear sessions if I am not in a private place during the session and will take reasonable steps to participate in therapy only while in an area where other people are not present and cannot overhear the conversation. DTS utilizes a secure videoconferencing site, which is HIPPA compliant, and while this is a secure site, I understand that technology is not 100% fail-safe and may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. I have the right to refuse teletherapy services if offered. *Initials:*_____

Group Therapy
If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside the group setting. *Initials:*_____

Minors and Parents
Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless the therapist decides that such access is likely to injure the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful

progress, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case, we will notify the parents of this concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and address any objections. *Initials:*_____

Confidentiality

The Therapist at Discovery Therapeutic Services is bound by professional ethics to protect client rights to confidential communication. All issues discussed in the course of counseling are strictly confidential (including children age 14 years and older).

By law, health care information pertaining to you may be released only with your written consent or the consent of a parent or legal guardian. For this reason, if you want your therapist to release information about your participation in therapy, you will be asked to sign a "Release of Information," valid for ninety (90) days from the date of signature. The law does provide exceptions to client confidentiality where information may be released without your consent:

1. In the event of a medical emergency, information deemed necessary for treatment may be released.

2. In the event of a threat of harm to oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom a threat is made.

3. In the event of suspected abuse of a child, dependent adult or elder, the proper authorities must be contacted. The abuse does not have to be personally witnessed by the counselor.

4. If ordered by a judge or other judicial officers, information regarding your treatment must be disclosed. *Initials:*_____

Records Review & Correction

Discovery Therapeutic Services will keep records of the mental health care services provided to you. You have a right, by law, to see and copy that record and to make corrections to your record. In the event records are requested, a summary of treatment and general notes will be given. A reasonable fee will be charged for reviewing and/or photocopying any portion of your record. This does not include

disability claims as this office does not submit any information for disability claims.
*Initials:*_____

Non-Discrimination Policy
Discovery Therapeutic Services does not discriminate against any person because of race, color, national origin, sex, income, age, religion, creed, marital status, sexual orientation, or the presence of any physical, mental, or sensory disability. No person shall on the grounds of race, color, national origin, sex, or age be excluded from participation in any counseling programs or other services provided by the Therapist. *Initials:*_____

Involvement in Treatment
You have the right to receive psychotherapy services in the least restrictive setting possible as well as be an active participant in your treatment. Your commitment to an agreed upon treatment plan is necessary to experience the most successful outcome. If you ever have questions about the nature of your treatment, please do not hesitate to ask. If, for some reason, you are not satisfied with the therapy progress, treatment approach, or goals, you have a right and responsibility to address this with the psychotherapist to discuss treatment revisions. You also have the right to end treatment at any time.
*Initials:*_____

Consent for Treatment
I have read, initialed, and understand the above policies and procedures and informed consent information of Discovery Therapeutic Services. I also understand that, while the course of my treatment is designed to be helpful, there are no guarantees to the outcome of my treatment and that I agree to be an active participant in my therapy. I understand that I may terminate treatment at any time and that if I have any complaint or grievance regarding my treatment, I will be provided assistance. I agree to the stated terms of treatment and hereby give my consent for treatment to my child and/or me. I also acknowledge that I have been given a copy of this agreement.

Client/ Parent/ Guardian

_____ Date _____

Monica L Olson, MS, LPCC (Therapist)

_____ Date _____

315 Main Street South, Ste 311, Minot, ND 58701
Phone: 720.248.8315; Email:monicalolson@protonmail.com

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the child or dependent and on the child's or dependent's behalf, I legally authorize Discovery Therapeutic Services to deliver mental health care services to the following child or dependent:

_____ _____
Child or Dependent's Full Name (Print) Social Security #

_____ _____
Signature of Legal Guardian/Representative Date

_____ _____
Relationship to Child or Dependent Benefit Plan Subscriber Name

_____
Mental Health Benefit Plan

By signing below, I understand that I will be financially responsible for any damages caused by _____
Child or Dependent's name

_____
Signature of Legal Guardian/Representative

315 Main Street South, Ste 311, Minot, ND 58701
Phone: 720.248.8315; Email:monicalolson@protonmail.com