Therapy Solutions
1679 6th Ave W
Dickinson, ND 58601-2647
Phone: 701-483-1000 | Fax: 701-483-1001

Informed Consent Form

1. Emergency Management between sessions was discussed. After Hours Emergency contacts were given to the client.
2. Therapist is a Mandated Reporter
3. Therapist has a Duty to Warn
    a. Exception: If a minor age 14 to 18, discloses alcohol/drug use, to his or her therapist, Federal Rule (42 CFR Part 12) prohibits a Therapist from disclosing knowledge of drug/alcohol use to a guardian.
4. Client was informed of Confidentiality, Privacy, Security of sessions and records
5. Diagnosis, treatment, duration, risks and benefits and alternative options have been discussed.
6. Client was informed not to send E-Mails that are confidential or urgent information to their therapist's via e-mail. If there is an urgent matter, they were informed to call the office number or the emergency numbers that were discussed
7. Client was informed of the $50 cancellation fee.
8. Client was informed of the Walk Talk Therapy Policy.
9. If you are seen in the community, you will not be acknowledged due to breach of confidentiality
10. Social Media Policy – Therapy Solutions Staff will not interact with clients through social media
11. Client may not record session without written consent of the Therapist
12. I acknowledge, understand and consent that there is a security camera in the therapy room and have been informed that there is no audio.The video is confidential and not viewed by anyone unless there is a discrepancy about conduct in the session.

My signature indicates I was informed of the information above and agree with the information stated

Client Signature:

Date :

Guardian Signature (if applicable):

Date :