Informed Consent

Regarding Counselor Clinical Supervision

For Licensure to the Counseling Clients of

Rose Eldreth MA Associate Professional Counselor
23 Eastbrook Bend, Suite 204, Peachtree City GA 30269

Integrative Mental Health Counseling

This letter is to inform you that by way of my education, training, and employment status as your Counselor/Therapist I am working to fulfill the requirements to become a Licensed Professional Counselor in the state of Georgia. Because I am working toward licensure, I have a Clinical Supervisor who is a Licensed Professional Counselor (LPC) and a Certified Professional Counselor Supervisor (CPCS, Approved by the Licensed Professional Counselor Association of Georgia).

My Supervisor's information is as follows:
Natalie Kohlhaas MA LPC NCC
Work# 404-542-3502
Email: imhcounseling@yahoo.com
www.Natalie-Kohlhaas-LPC.com

I meet with her weekly in the form of individual supervision / a supervision group and for individual evaluation meetings at least twice a year to obtain guidance in the methods of counseling. Based on counseling ethical codes and guidelines you have a right to know that I am being supervised and that my supervisor's primary role is to ensure the well being of you my client(s). As part of the supervision process I do discuss my counseling work and my clients. Client identifying information is encrypted utilizing initials or some other form of encryption to keep information protected in accordance with HIPAA regulations. The setting of my Supervisor's office is a private and confidential setting.

My Supervisor will occasionally evaluate my performance by using one of several possible methods. The first of which could be listening to an audio recording of my counseling sessions with a client, second via direct observation, and third based on self-report. If I plan to use an audio recording, I will obtain your written consent and the audio recording will be destroyed once my supervisor has had an opportunity to review it. I will not use direct observation as a method without your consent.

Your signature below indicates that you understand that I am being supervised and that my supervisor will know the nature of our therapeutic interactions to ensure the best care possible.

_____ _____
Client Signature Date

_____
Printed Name

_____
Full Address Phone

_____
Emergency Contact Name Relationship Phone

_____ _____
Therapist Signature Date