☎ **(603) 865-1321**
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CONSENT AND AGREEMENT FOR CLINICAL OBSERVATION

We at Counseling Associates are dedicated to empowering our clients to a place of new possibilities through a process of healing and growing within a supportive and compassionate environment. As part of Counseling Associates' efforts to ensure that quality care is provided to all our clients, we encourage clinical interns to observe sessions by licensed therapists as part of their internship experience. Clinical interns are graduate students in a Psychology Training Program and are working under the direct supervision of a licensed therapist.

We would like to know your comfort level with any or all of the following. Please initial all you are willing to allow for preparation of competent therapists for our community in the future.

I hereby submit my consent to Counseling Associates for:

_☐_ *a clinical intern to observe my sessions with a licensed therapist either via telehealth monitor or in person.*

_☐_ *audio recording of my therapy session for training and/or supervision*

_☐_ *video recording of my therapy session for training and/or supervision*

***AGREEMENT**:*
I understand that if I agree to be video recorded or audio recorded, the information will be used solely for training purposes. I understand that I may revoke this authorization in writing at any time for any reason. In the event that I decide to rescind this agreement, I will inform my therapist and/or front office staff for the requested changes to take place. Recordings will be destroyed or kept in my chart as part of my clinical record and be available as part of my request record in compliance with prevailing HIPAA and Health & Human Services laws regarding the storage of medical and mental health records. By signing below, I acknowledged that I have read, understood, and agree to everything in this Agreement. I am voluntarily consenting to the above.

Further, if the client is a minor child, I acknowledge, represent, and warrant that I have the legal right to agree to the procedures indicated on behalf of the child named below.

My Child: _____ Date: _____

Client/Guardian Signature:_____ Date: _____

Therapist Signature: _____ Date: _____

Intern Signature: _____ Date: _____