

Appendix I: Informed Consent and Statement of Confidentiality

(To be copied and provided to each client with original signed & placed in client file on site)

Informed Consent

I, _____, (client/Parent/Legal Guardian) understand that this form is intended to help explain the process of receiving counseling services. I understand that _____, a counseling student at Webster University is a counselor in training (herein referred to as Student Counselor). This Student Counselor is working under the direct supervision of _____, a faculty member for Webster University and _____, a licensed supervisor for _____ (name of site). By signing at the bottom of the page, I agree to the following.

It has been explained to me that counseling services and psychotherapy have benefits and risks. Research has evidenced that receiving counseling services in times of emotional distress is more beneficial than receiving no counseling at all. Yet, there are no guarantees regarding treatment outcomes.

I understand that video or audio taping or live supervision may be used in counseling sessions. These tapes may be shared with other counseling students for purposes of training only. Tapes pertaining to counseling sessions will be maintained in a secured location and will be destroyed by the end of the Practicum term or these counseling sessions.

I understand that I have the right to ask about any aspect of counseling or to terminate counseling sessions at any time.

I understand that I have the right to an explanation of any test/questionnaire I may be given, to decline participation in any such test or questionnaire, and to a summary, either verbal or written, of any test results/conclusions.

I understand that if I find myself in an emergency emotional situation (I feel like hurting myself or another), I agree to contact _____ (phone number of the nearest hospital emergency room) before I take any other action and ask for the mental health professional on call. I may contact my counselor in training or the named supervisor above after I contact the emergency room.

Statement of Confidentiality

I understand that there are specific situations in which my confidentiality may be broken and in which the Student Counselor and or supervisor is legally obligated to take actions that may be necessary to protect me or others from harm. If such a situation arises, it will be discussed with me before any action takes place.

I understand that the reasons for which my confidentiality may be broken include the following:

1. If it is suspected that a child or a vulnerable adult is being neglected and or abused.
2. If it is suspected that I, the client, present a clear and substantial danger to myself or other(s).
3. If there is a court order regarding the contents of my case.

Resulting actions may include contacting family members, seeking hospitalization, notifying potential targets, and notifying the police.

I understand that these counseling sessions may be terminated by me at any time and that the Student Counselor may, with advanced notice, refer me to another counselor. I also understand that the Student Counselor will end

his/her relationship with this site at a set time and that I have been notified that sessions may not occur with this Student Counselor beyond _____ (date of end of field experience).

I understand that this summary is designed to provide an overview of confidentiality and the limits of professional counseling. I understand that this form is required to be signed to by me before professional counseling services can be provided.

I have read and understand the above and have had the opportunity to ask questions regarding the counseling process before revealing personal information about myself.

Client/Parent/Legal Guardian Signature

Printed Name

Date

Counselor (Student) Intern Signature

Printed Name

Date

Licensed Supervisor Signature

Printed Name

Date