SCHOOL OF NATURAL
AND SOCIAL SCIENCES

Master of Arts in Clinical Mental Health Counseling

INFORMED CONSENT FORM

Client's Name:_____ Date of Birth:_____

This informed consent document is intended to provide general information about the counseling services provided by East Texas Baptist University Master of Arts in Counseling graduate student. This is a legal document; please read it carefully before signing.

- **Nature of Counseling:** The type and extent of services that I/my child will receive will be determined following an initial assessment and through discussion with me. I understand that there may be both benefits and risks associated with participation in counseling. Counseling may improve ability to relate to others, provide a clearer understanding of self, values, and goals, and an ability to deal with everyday stress. I understand that counseling may also lead to unanticipated feelings and change, which might have an unexpected impact on me/my child and my/my child's relationships.

- **Supervision:** I understand that _____ (full legal name of counselor-in-training):
  - is currently completing his/her Master of Arts in Counseling degree at East Texas Baptist University. In order to improve his/her skills, he/she is required to complete a practicum and two internships.
  - is currently under the direction of a site supervisor that is required to have a minimum of a master's degree; preferably in a counseling, or a related profession with relevant certifications and/or licenses; a minimum of two years of pertinent professional experience; knowledge of ETBU's counseling program requirements, expectations, and evaluation procedures; and relevant counseling supervision training.
  - is currently supervised by a site supervisor at _____ (agency) and an East Texas Baptist University faculty supervisor.
  - will be on-site regularly until _____ (date of last day on-site).

- **Confidentiality:** I understand that counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective counseling, however, sometimes requires that confidential information be shared with other staff members, professors, or graduate students who are training at East Texas Baptist University. When confidential information must be shared, pseudonyms (false names) are used to protect the identity of the client. I understand that no records or information about me will be released outside East Texas Baptist University without my permission, except under certain circumstances: if I/my child present/presents a serious danger to self or other person(s); if there is a suspicion or actual incident of child abuse or neglect; or a valid subpoena is issued for my/my child's records, or my/my child's records are otherwise subject to a court order or other legal process requiring disclosure.

- **Video/Audio Recording of Counseling Sessions:** I understand that the East Texas Baptist University counselor-in-training routinely records counseling sessions. I understand that such recordings will only be used for educational purposes and that the professors and/or students involved will respect and protect the confidential nature of the sessions. It is understood that the recordings will be confidential and only reviewed for supervision or educational purposes and will subsequently be erased by the counselor-in-training within 90 days or at the end of the semester, whichever comes first. I understand that because these are digital recordings, confidentiality is limited by the secureness of the technology being used to store them. All efforts are made to keep recordings confidential but the possibility of unforeseen technological events mean that confidentiality cannot be absolutely guaranteed. I understand that all such recordings are property of the East Texas Baptist University Masters of Arts in Counseling department.

If I have any questions regarding this consent form or about the services offered, I understand that I may discuss them with my counselor-in-training or his/her site supervisor.

I have read and I understand the above. I understand that treatment may be stopped at any time and there are no penalties for denying permission. I hereby consent to:

☐ permit myself/my child to participate in the above described counseling activities

☐ ONLY without recording it;
OR
☐ I permit audio or video recording of the counseling sessions.

Signatures Required:

Client Full Legal Name (please print)	Signature	Date
Parent/Guardian Full Legal Name (please print) *(Required for clients under 14 years of age)*	Signature	Date
Counselor-in-training Full Legal Name (please print)	Signature	Date
Site Supervisor Full Legal Name (please print)	Signature	Date

- Client signature is needed if client is 18 or over.
- Either parent/guardian or client signature is needed if client is 14-17.
- Parent or legal guardian signature is needed if client is under 14.