



NWC COUNSELING

COUNSELING INDIVIDUALS COUPLES FAMILIES

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CONSENT AND AGREEMENT FOR CLINICAL INTERN WORK

We at NWC Counseling LLC (NWCC), 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 a part of NWCC’s efforts to ensure that quality care is provided to all our clients, we encourage clinical interns to observe and/or provide therapeutic sessions supervised by licensed therapist as a part of their internship/externship/ provisional license experience. Clinical Interns are graduate students in a Clinical Counseling Program from an area/online university OR post-graduate Licensed professional counselor interns (LPCI) completing the required 3000-hour internship for permanent licensure by the state of South Carolina; both of which are working under the direct supervision of a licensed therapist at NWCC Clinical Supervisor Candidate by the Board of Licensed Professional Counselors of South Carolina. 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 NWCC for:

- _____ a clinical intern to sit in, observe, and/or conduct my sessions under the supervision of licensed therapist;
- _____ a licensed therapist to sit in and observe the work of a clinical intern for the purpose of clinical supervision and improvement of the intern’s skill level (this only applies if the therapist is an intern)
- _____ audio recording of my therapy session for training and/or supervision
- _____ video recording of my therapy session for training and/or supervision

I hereby DO NOT submit my consent to NWCC for:

- _____ a clinical intern to sit in and observe my sessions with a licensed therapist;
- _____ a licensed therapist to sit in and observe the work of a clinical intern for the purpose of clinical supervision and improvement of the intern’s skill level (this only applies if the therapist is an intern)
- _____ 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 not be shared outside of NWC Counseling LLC., but may be shared at the practice’s clinical staff meetings 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 a part of my clinical record and be available as part of my request record in compliance with prevailing HIPAA and Health and Human Services laws regarding the storage of medical and mental health records. **By signing below, I acknowledge** 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 legal right to agree to the procedures indicated on behalf of the child named below.

Client Signature

Date

NWCC Signature

Date