

# METROPLEX COUNSELING

## A Center for Biblical Soul Care

209 N. Industrial Blvd.  
Ft. Worth, TX 76126

817-584-3361  
www.metroplexcounseling.com

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### INTERN CONSENT FORM

Your counselor holds a temporary license from the state of Texas, and is working towards obtaining the required 3000 hours to obtain professional licensure. He or she holds a graduate degree in counseling, and is currently under a state approved clinical supervisor.

Supervision consists of weekly case review, as well as occasional video or audio taping of sessions, with the client's permission. Communications between you and your counselor and your records, however created or stored, will be confidential under applicable statutes and rules. Neither your counselor, nor the supervisor, will disclose any communication, record or identity of you, except as provided by applicable statutes or rules.

I do \_\_\_ do not \_\_\_ give my consent for video or audio taping (initial in appropriate blank).

The supervisor under which your counselor is working is listed below. Additionally, the center director of Metroplex Counseling has been listed should you deem it necessary to confer with him as well.

#### Clinical Supervisor Contact Information

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

#### Center Director Contact Information

**Name:** Steve Clay, M.A., L.P.C.

**Address:** 209 N. Industrial Blvd.#237, Bedford, TX 76021

**Phone:** 817-571-4110

**Email:** [steve@metroplexcounseling.com](mailto:steve@metroplexcounseling.com)

By signing this document, you acknowledge that you have been informed of the intern status of your counselor. You also agree to allow your counselor to confer with his/her supervisor and director regarding your case for the purposes of professional training. Should you have any questions or concerns regarding this issue, please promptly bring this to your counselor's attention. We are here to serve you!

Client/Guardian

Printed

Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor

Printed

Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_