**Couples and Family Clinic**

**University of Florida Department of Counselor Education**

**Declaration of Informed Consent**

Welcome to the Couple and Family Clinic (CFC), a service of the Department of Counselor Education at the University of Florida. An important goal of the department is providing you and your family the best possible services. We utilize a team approach to couples and family counseling. One or two members of the team will conduct your sessions, while the rest of the team observes and consults from a separate room.

Graduate students from the Counselor Education Program staff the CFC. All sessions are recorded and monitored by closed circuit TV – these recordings are for educational and supervision purposes only and are the sole property of the clinic. A faculty member and/or advanced graduate student learning clinical supervision skills observe the counseling session. Your Counselor (a graduate student) receives consultation and suggestions from the supervisor(s) and the team who are viewing the sessions. In some instances, other graduate students-in-training or professionals will participate in these conferences. These activities are intended to ensure that you are receiving the highest level of quality service. You have the right to request the name of the supervisor and meet the team.

**Client Information**

The Couples and Family Clinic (CFC) adheres to both the ethical standards of the **American Counseling Association** (ACA),the **American Association for Marriage & Family Therapists** (AAMFT) and the **Laws and Rules of the State of Florida**. The information shared during the counseling process will be kept strictly confidential, except for those reasons required by law. These exceptions include the following:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. Information will only be shared with a person or organization that is able to help prevent or reduce the threat.
2. When there is suspected abuse or neglect of a child, elderly person, resident of an institution, or a disabled person.
3. As a result of any lawsuit against the counselor and/or legal/court proceedings.
4. If a law enforcement official requires a release.
5. When you (the client) explicitly request in writing that information be shared with a third party.

(ACA Code of Ethics [2005], Section B.2; Chapter 491, state of Florida law governing the practice of Clinical, Counseling, and Psychotherapy Services [2010], Section 491.0147)

**Confidentiality**

Confidentiality will be strictly maintained to the extent provided by law. Information will not be released to any person or agency without your knowledge and/or written permission (with the exception of legal exclusions such as duty to warn situations, mandated abuse reporting and legally mandated requests for information). All videos are securely kept on the property and are used by authorized personnel only.The videos will be used for instructional and supervisory purposes, and all participant-observers will maintain confidentiality as prescribed by the professional ethical/legal standards of Florida Law, ACA and AAMFT.

**Consent for Treatment**

In signing below, I acknowledge that I have received, read and understand this **Client Information and Consent for Treatment** form. I have had an opportunity to ask questions and receive answers. I do hereby seek and consent to take part in treatment by the Counselor named below. I understand that treatment may include individual, couples, family or group counseling and may include consultations with other associates of this institution. The treatment may also include referrals to other appropriate State, County, and/or professional agencies for further counseling. I understand that developing a treatment plan with the Counselor and regularly reviewing our work toward meeting the treatment goals are in my best interests. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the Counselor. I am aware that I may stop my treatment with the Counselor at any time. I know I must call to cancel or reschedule an appointment at least 24 hours in advance. I know I may receive confirmation calls or letters of follow-up on missed appointments. I acknowledge that this Clinic is a training facility and give my permission to have my Counselor’s supervisors review all aspects of my treatment.

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**Client(s) Printed Name(s)**

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**Client Signature Date**

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**Client Signature Date**

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**Client Signature Date**

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**Parent(s)/Guardian(s) Signature (for minor clients) Date**

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**Parent(s)/Guardian(s) Signature (for minor clients) Date**

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**Counselor Signature Date**

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**Supervisor Signature Date**