



# THE INSTITUTE FOR EXPRESSIVE ANALYSIS

## CC SUPERVISION CONSENT

### CONSENT FORM FOR ALL OF IEA CC AFFILIATES (BOTH TRACK I AND TRACK II)

I (Name, date) \_\_\_\_\_ understand that because it is in my best interest to get as wide a range of clinical experience while in training, barring special reasons, I am expected to accept patients irrespective of diagnosis, prognosis, and fees. I understand that patients are assigned to one therapist affiliate at a time. Patients have the right to request a transfer to a different therapist if for whatever reason they may not feel comfortable with the therapist to whom they were first assigned. I agree to bring to supervision the treatment processes of all patients referred by the IEA Consultation Center. I will use the IEA CC Manual and student handbook as reference to implement policies and discuss these issues with my supervisor. I understand that any changes in patient's mental status / issues of safety, will be immediately discussed with my supervisor in order to ensure quality of care. I understand that any changes in fee will be first discussed with my supervisor. I understand that when a patient terminates, I will discuss this with my supervisor and when appropriate, refer the patient back to the consultation center or provide other resources for treatment.

I, \_\_\_\_\_ (the affiliate) will provide the following annual reports/updates, for all of the IEA Consultation Center patients, signed by my supervisor and myself. Status reports, Progress Report, Termination Report, Yearly Review

Name title/degree of supervisee \_\_\_\_\_

Signature/Date \_\_\_\_\_

### SUPERVISOR AGREEMENT:

I (Name/title/ degree ) \_\_\_\_\_ agree to supervise \_\_\_\_\_ (IEA candidate) on the treatment of all patients referred by the Consultation Center for Expressive Analysis. I will do so in accordance with the standards and regulations of the consultation center and I agree to submit an annual evaluation of the student's work to the Dean of Training of the Institute for Expressive Analysis. **I am aware that by signing, I am agreeing to the legal clinical responsibility for all of the named supervisee's clients unless they are already licensed to provide psychoanalysis (LCSW, MD, RN, NP).**

I agree to make an arrangement to discuss any clinical issues that requires immediate attention. In case there is a clinical need, I will assist the affiliate with finding auxiliary treatment- such as psychiatric evaluation, substance abuse rehab, etc.

Name title/degree of supervisor \_\_\_\_\_

Signature/Date \_\_\_\_\_