

**Innovations Counseling and Consulting PLLC**  
**Informed Consent to see a Practicum or Intern Counselor**

- Please make no marks/add comments to this portion of the document. It is your consent for psychotherapy services and your treatment is conditional on your signing this consent without modification.
- I understand the therapist is practicing under the supervision of Kevin Glasser, LPC-S or another staff LPC-Supervisor.
- I understand that the therapists abide by state and federal regulations regarding health and medical record keeping and confidentiality (most commonly known as HIPPA regulations) and that a copy of this document has been provided to me to review in the office.
- I understand that if any assignment is given that I disagree with morally, ethically, spiritually, or emotionally that I have the right not to proceed with that assignment. I understand that if I am concerned with slow progress or lack of progress I have the right to speak about my concerns.
- I understand that there are some occasions when confidentiality can/must be breeched. These are: a) I sign a Release of Information Form or I verbally direct my counselor to tell someone else, b) My counselor determines that his/her client poses a threat to self or others, c) My counselor is ordered by a court to disclose information, or d) My counselor suspects child/elder abuse has taken place and will notify Child/Adult Protective Services.
- I understand that counseling can improve as well as upset the equilibrium in any person, relationship, or family.
- I understand that as a participant of a counseling group (if applicable) I am expected to uphold confidentiality. No aspect of the group may be discussed to anyone outside of the group.
- I understand that my counselor is a Practicum level student or an Intern. Practicum students are Master's level students working towards a Master's Degree in a counseling related field. Thus, practicum students are not licensed. Interns have earned their Master's Degree and are provisionally licensed while gaining the necessary clinical hours to receive full licensure.
- I understand that my name and certain aspects of my case may be disclosed to supervisors during the course of practicum/supervision so that I may have the best care possible.
- I understand that Practicum students and Interns do not provide services for clients needing legal/court input and/or disability input.
- I agree to be responsible for all payment rendered on my or my dependent's behalf. Fees for Practicum Students are \$30.00 per session and Interns are \$80.00 per session.
- I agree to notify your office 24 hours in advance if I need to reschedule/cancel an appointment.

Any questions or concerns can be communicated to:

Kevin Glasser, MA, LPC-S  
11999 Katy Freeway, Suite 490  
Houston, Texas 77079  
281.597.9291  
Kevin@InnovationsCounseling.com

I have read, understand, and agree to the above terms.

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

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

Counselor Name/Credential: \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_