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LPC Associate Counseling Agreement

Please initial the following statements to acknowledge your understanding:

- _____ I understand that I am seeing a counseling Associate for counseling services.
This associate is earning hours towards full counseling licensure.
- _____ I understand the limits of confidentiality as explained by my counselor and have had the opportunity to ask questions about these limits.
- _____ I understand that I may, at any time, request to see the associate's supervisor, Dr. Ellen Melton, LPC-S for questions or consultation regarding my therapy.
- _____ I understand that the dynamics of my child's case will be discussed for staffing and educational requirements with the counseling associate and supervisor.
- _____ I understand that some sessions may be directly observed by the LPC Supervisor.
- _____ I understand that some sessions may be audiotaped and/or videotaped for supervision and educational purposes.
- _____ I understand the supervisory relationship and the requirement for supervision do not otherwise affect my right to confidentiality, which will be maintained within the limits of the law.

Client's printed name

Date

Signature of Client OR Parent/Guardian, if client is under 18 years of age