Local, National & Global
TRANSFORMED HEARTS
Counseling Center

SUPERVISION AGREEMENT

SUPERVISOR INFORMATION

Today's Date ____ / ____ / ____

Cory M. Schortzman, MA, LPC, SRT's credentials include the following:

B.A, Doane College, Crete, Nebraska, May 1997
Master's in Counseling, Denver Theological Seminary, Denver, Colorado, May 2000
Licensed Professional Counselor, Colorado LPC License #4905, February 2008
Licensed Mental Health Practitioner, Nebraska LMHP License #2424, September 2003
Licensed Independent Mental Health Practitioner, Nebraska LIMHP License #259, December 2007
Sexual Recovery Therapist, American Association of Sex Addiction Therapy, #606 February 2009
Certified Recovery Therapist, Founder & Supervisor, Sexual Addiction Recovery Association

SUPERVISEE INFORMATION

Name _____ DOB ___ / ___ / ____ (___ ___)
First Name Last Name Age

Address _____ _____ _____ _____
Street City State Zip Code

_____ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Email Home Telephone Number

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Work Telephone Number Mobile Telephone Number

Start Date: ___ / ___ / ____ **Approximate End Date:** ___ / ___ / ____

Frequency of Supervision
☐ Weekly
☐ Biweekly
☐ Other_____
(Please check one.)

Duration of Supervision
☐ _____ Weeks
☐ _____ Months
☐ Other_____
(Please indicate number of weeks, months, etc.)

Venue
☐ Face-to-face
☐ Telephone
☐ Other _____
(Please check one.)

Session Length
☐ 30 min
☐ 60 min
☐ 90 min
☐ 120 min

SUPERVISION TYPE
☐ AASAT ☐ Practicum ☐ Internship ☐ State Licensure

GENERAL GUIDELINES

To ensure you have understood our general guidelines, place initial each box below.

1. _____ The clinical supervisor is not providing clinical oversight for services, therefore are not liable for the supervisee's clinical errors (omission or commission).

2. _____ The clinical supervisor is providing clinical consultation on skill development and informed clinical techniques related to typical clinical scenarios.

3. _____ The clinical supervisor is providing training for clinical practice skills.

4. _____ No names or other identifying information will be included in discussion.

5. _____ The clinical supervisor will provide information, skills practice, advice and opinions about typical and atypical clinical situations but not on specific cases.

6. _____ The supervisee is required to provide the clinical supervisor with a copy of their own clinical professional liability insurance coverage and provisional or state licensure with this form.

7. _____ The supervisee agrees to indemnify the supervisor and hold them harmless in any future complaint or liability action against the supervisee.

8. _____ Both the supervisee and supervisor shall adhere to the application code of ethics and standards of practice for their discipline as well as to state statutes.

9. _____ Intern, practicum and provisional license supervisees shall provide a full disclosure of the supervised nature of their work, which shall include the name, address and telephone number of their designated qualified clinical supervisor.

10. _____ Supervisor is responsible for record keeping of dates and times of supervision sessions.

11. _____ The supervisee and supervisor must sign and date this agreement.

CONFIDENTIALITY & RELEASE OF INFORMATION

The information provided by the client, the supervisee and supervisor is generally legally confidential and cannot be forced to be disclosed. Information disclosed is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates. The exceptions to the general rule of legal confidentiality are listed in the Colorado statues (C.R.S. 12-43-218). However, please be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S.

The supervisee understands the following exceptions to confidentiality, which include but are not limited to:

1. Any evidence or disclosure by the client of perpetrating child or elderly abuse (past or present, physical or sexual abuse) must be reported to Legal Authorities.
2. Any evidence or disclosure by the client of downloading child pornography (past or present) must be reported to Legal Authorities.
3. Any evidence or disclosure by the client of any suspected threat to national security to federal officials.

4. If an individual intends to take harmful, dangerous or criminal actions against another human being or against him/herself, it is my duty to report such action or intent to medical and legal authorities. In the unlikely event, it is my clinical judgment that you are a danger to yourself or someone else, by signing the consent, you authorize me to contact either the persons listed as your emergency contacts, or someone else to provide assistance through this crisis situation. This would include, at our discretion, contacting an intended victim. By law, your consent is not necessary.
5. Sexual improprieties by a former therapist are a criminal offense and must be reported.
6. Certain court orders/actions, such as custody cases, malpractice actions, etc., may legally require disclosure of certain material covered in our sessions.
7. Collection of fees may require disclosure that you have been in a counseling process.
8. Consultation and Supervision with other professionals to aid in your treatment process.

If the supervisee is requesting supervision for AASAT certification, supervisee agrees to allow the supervisor to consult with Douglas Weiss, Ph.D as needed as well as provide documentation of completed supervision hours.

SUPERVISION FEES

The fee for supervision is $ _____._____ per supervised session. Supervision fees vary by type. By consenting to supervision with Cory M. Schortzman, MA, LPC, SRT you acknowledge you are responsible for the cost of the provided services at the time the service is rendered. Payment is expected at the beginning of each month. I offer the use of credit cards for your convenience. If you select this method of payment, your credit card will be charged the first of the month.

PAYMENT METHOD

❑ Cash ❑ Check ❑ Credit Card ❑ Other _____

Credit Card Number ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

CVC2 Code ___ ___ ___ ___ Expiration Date ___ ___ /___ ___

(The CVC2 code is a 3 or 4-digit number located on the back of your credit card.)

By signing below you agree that you have read and understood the above information and are consenting to supervision with Transformed Hearts Counseling Center, Inc., Cory M. Schortzman, MA, LPC, SRT. The signed copy of this document will become part of your file at Transformed Hearts. If you have any questions, please address them before our initial supervision session.

_____ _____

Supervisee's Printed Name Supervisee's Signature Date

_____

Therapist Signature Date