Supervision Contract

We have decided to enter-into a supervision experience together, and we have gone over a number of issues in order to help us create an agreed upon context for that experience. The purpose of this contract is to outline those issues to serve as a resource for our work together as you progress towards licensure.

Supervisor: Andrea Mamalakis Epting, NCC LPC, MAC, CPCS, ACS, CST (CPCS# 634, ACS#02378, License # LPC005849)

Outline of Logistics

Group Supervision: Group Supervision will be provided by a CPCS/ACS for a total of 3-6 associate licensed clinicians working towards full licensure and fully licensed clinicians working to maintain their current license in the state of GA.

Group Supervision will be held Biweekly on Monday at 11:00 & Tuesday at 12:00 for a minimum of 60 minutes (Days/Times subject to change – Group will be offered 4 times per Month).

Fee for Service(s):

$35 per Group Supervision with Contracted Associate level Clinicians
$125 per Individual or Paired Supervision with Contracted Associate level Clinicians
$125 Required Annual Evaluation/ Clinical Observation
$Free to HUGS Contracted Clinicians Volunteering 6+ hrs. Wkly (Providing 4-6 services weekly to HUGS clients)

Individual & Paired Supervision: Supervision will be provided by a CPCS/ACS *"As Needed/As Scheduled"* to contracted associate licensed clinicians working towards full licensure and fully licensed clinicians working to maintain their current license in the state of GA.

Individual Supervision will be provided "as scheduled" &/or "when required" to contracted Supervisees for a maximum of 50 minutes (this includes mandatory annual evaluations & Reviews – required of ALL contracted Supervisees).

Paired Supervision will be provided "as scheduled" &/or "when required" to two contracted Supervisees for a minimum of 60 minutes (this includes mandatory annual evaluations & Reviews – required of ALL contracted Supervisees).

PAYMENTS: *I AGREE TO REMIT PAYMENT AT THE BEGINNING OF EACH MONTH TO PROVIDE SERVICES UNDER MY SUPERVISORS LICENSE, AND UNDERSTAND THAT I DO NOT HAVE PERMISSION TO PRACTICE UNDER THEIR LICENSE UNLESS PAYMENT HAS BEEN MADE IN FULL BY THE 1ST DAY OF EACH MONTH.* _______

CHECK ONE: *$150.42 (+ $5 Credit Card Fee) per contracted Month (no less than 12 Months). Includes group 4xMonthly & Annual Evaluation* _____

$275.42 (+ $5 Credit Card Fee) per contracted Month (no less than 12 Months). Includes Group 4xMonthly, Annual Evaluation, and Individual/Paired Supervision 1xMonthly _____

Cancelation Policy: There is a 48-hour cancellation policy. After three late cancellations or no shows the contracted supervisee will be terminated, and Supervisee will receive an invoice for the remainder of the contracted year. In this event Supervisee is subject to a "Do Not Recommend" sent to the licensing board. This policy ensures attendance and full group participation. Please plan for 90-minute sessions when scheduling to ensure proper planning and time management (as we may tend to run over depending on topic and group size).

Supervisee Responsibilities: Complete initial supervision contract, copy of GA license/Approval Letter, Copy of Licensure Application, copy of current professional liability insurance, Background Check Form, business license (if applicable), Driver's license, proof of employment (if applicable), MA/MS program Transcripts (if required), Provide updated contact for self & Employer/Director/Supervisor, Supervision Action Plan (outline of how you will accomplish/achieve required licensure hours with regards to supervision [group & individual] and clinical contact hours), and to keep a log of supervision dates/times/topics and present to supervisor for signature monthly.

Confidentiality: This is a confidential group. Personal information and life experiences need to be freely offered as part of group experience without fear. Confidentiality also protects the employers of participating clinicians, and the clients of participating clinicians. Supervisor will keep a file on you (and it is your responsibility to keep your information updated). This file and your personal information is confidential and will be kept secure at all times.

Supervisor Brief Bio:

Andrea is the founder and CEO of Heads-Up Guidance Services (HUGS) (since 2009), and Owner/ Clinical Director of Resolve Strategies, LLC (since 2018) – both operated in Savannah, GA. After graduating from the University of Alabama with a double major in Psychology and Religious Studies, she earned her Master's in Psychology with a specialty in Professional Counseling in 2006. Andrea has been working locally in the field of Addiction and Mental Health since 2003, and has been licensed as a LPC since 2010. She is a practicing Licensed Professional Counselor, Masters Addictions Counselor, Certified Sex Therapist and Approved Counselor Supervisor. She specializes in trauma-induced process addictions (primarily sexual compulsivity), Trauma Recovery, Chemical Dependency (Substance Related Disorders), Eating Disorders, and Sexual dysfunction. She is EMDR trained 2019/certified 2020, and working as a CPCS/ACS since 2016.

I understand the limits to confidentiality with regards to my information and any notes that my Supervisor makes with regards to our conversations in or outside of Group/ Paired Supervision.

(initial to verify that you understand each limit to confidentiality with regards to your clinical Group Supervision)

_______ *I understand that my supervisor's notes with regards to our discussions individually & in Group supervision could be Subpoenaed by the court of law. I understand that this is a limit to confidentiality and protected information.*

_______ *I understand that my supervisor is a Mandated reporter of any current or potential abuse, risk of harm to self, risk of harm to others, suicidal ideation, homicidal ideation.*

_______*I understand and give full permission for my supervisor to deny providing a reference, letter of recommendation, or letter of support. I understand her position as a gatekeeper for the field, and that my attendance does NOT entitle me to these things.*

_______*I understand and give full permission for my supervisor to report any unethical practices on the part of myself, my additional directors/supervisors,* and/or my workplace/employer to the licensing board to conduct a *professional/ethical review.*

_______*I understand and agree to comply fully with ACA/AMHCA/ACES Code(s) of ethics, and to report any disciplinary actions (legal, vocational, & clinical) to my Supervisor within one week of any incident despite the outcome.*

______ *I understand and will comply with this contract in its entirety. I clearly understand my responsibilities and*

have reviewed the supervisor/supervisee relationship in detail.

______ *I understand and agree to report ALL potential ethical dilemmas and/or ALL high-risk clients to my supervisor within 24 hours of any knowledge, and agree to process these dilemmas in a group setting.*

______ *I agree to provide my Supervisor with the contact information from any other supervisors/Directors overseeing my clinical hours or providing any form of supervision/Clinical Direction. I understand the desire for them to work collaboratively as I continue to grow/develop my skills and work in this field.*

_____ *I agree to schedule a private meeting (PRN individual supervision meeting) to discuss any problems I might have with the supervision group itself, group members, and/or questions/clarifications that you prefer to be discussed outside the group setting. I understand that there will be a potential fee of $75 for community counselors depending on the time needed to discuss and process.*

_____ *I agree to schedule and understand that it is required that ALL supervisees fully participate in and effectively complete an ANNUAL Supervisee Evaluation/Review to assess my progress, strengths, weaknesses, performance, compliance, clinical skills, professionalism, and overall development.*

_______*I understand that I must report ALL clinical practices, and agencies in which I provide services to clients/community.*

_______*I understand that I must operate within my "scope of practice."*

_______*I understand that if I'm deemed impaired, or unable to uphold my clinical responsibilities (for any reason), I will be terminated/reported and/or given a remediation plan. I will be required to comply with and complete my remediation plan within the specified amount of time.*

_______*I understand that my Supervisor may choose to terminate our supervisor upon any violations of the contract.*

FOR APC APPLICANTS & APC APPROVED COUNSELORS:

_____ *I FULLY UNDERSTAND THAT I'M NOT A LICENSED COUNSELOR, AND THAT I'M OPERATING UNDER THE LICENSE OF MY CONTRACTED SUPERVISOR(S). THEREFORE, I AGREE TO/ UNDERSTAND THAT ….*

To Comply with ALL clinical recommendations & implement immediately (especially regarding Ethics, Liability, Best Practices, & Client Care. ______

To Carry Individual Professional Liability Insurance & name my Supervisor/Supervisor's Practice as an "additional Insured" – And keep current with current declarations page provided to Supervisor (any lapses in coverage must be reported immediately). _______

To Provide a minimum of one month notice of contract termination/licensure completion, and to complete a "termination form" prior to the last scheduled session.

To Inform ALL clients that I'm practicing under supervision and indicate from whom you are receiving direct supervision and/or Direction (who's license you're practicing under). ______

I can NOT bill insurance as an APC. _______

I can NOT compose or submit Super Bill's for Client Reimbursement as an APC. _______ *I can NOT operate*

independently or as a private practitioner (without both supervision & direction). _______

Identification of goals: The goal is to meet regularly to fulfill licensure requirements in accordance with ACA/AMHCA/ACES and CPCS/ACS codes of Ethics. We will identify and discuss ethical dilemmas, work related stressors, self-care, licensure requirements, case conceptualization, and there will be use of role play to recreate clinical scenarios. We will work to identify your clinical style/approach/preferred techniques & population. There will be discussion and opportunity for respectful feedback. Anticipate homework as we all work to gain insight into new requirements, new techniques/therapies, and new research studies.

______ I understand that it is highly recommended that I become an active member of LPCA-GA.

Supervisee Signature: ______________________________ Date: ______________

Mobil:____________________________ Email:_____________________________

Employer/ Director Contact: ____

____

Supervisor (CPCS/ACS) Signature: ___________________________ Date: _____________