PHOENIX POINTE
PSYCHIATRY

Therapy Clinical Supervision Acknowledgment and Consent

I understand that my therapist at Phoenix Pointe Psychiatry may practice under the clinical supervision of a qualified, independently licensed behavioral health professional.

I acknowledge that the clinical supervisor may review my clinical records, including progress notes, assessments, treatment plans, treatment modalities, and other relevant documentation.

I understand that supervision may also involve discussion and review of my case, treatment progress, clinical concerns, and therapeutic approaches to ensure safe, ethical, and effective care. I understand that the clinical supervisor may occasionally observe therapy sessions, either in person or virtually, for the purposes of clinical supervision, evaluation, and professional development. I will be informed prior to any direct observation of my therapy session.

My information will be shared with the clinical supervisor only as appropriate for clinical supervision and in accordance with applicable confidentiality and privacy laws.

I understand that I may contact the clinical supervisor by contacting Phoenix Pointe Psychiatry at (480) 378-6323 or by email at info@phoenixpointepsychiatry.com.

By signing below, I acknowledge that I have been informed of the clinical supervision process and consent to the involvement of the clinical supervisor in my care.

Patient/Legal Guardian Name: _____

Patient/Legal Guardian Signature: _____

Date: _____

Associate Level Therapists:

- ☐ **Michele Craig, LAC**
- ☐ **Toni Lenox, LAC**
- ☐ **Krista Pellegrino, LAC**
- ☐ **Sarah Shipp, LMSW**
- ☐ **Taylor Winquist, LAC**

Supervising Therapist:

- ☐ **Hillary Bryant, LMFT**
- ☐ **Rachel Weinstock, LCSW**

Therapist Signature: _____