

Rochester Counseling Solutions  
1344 University Ave Suite 230  
Rochester NY 14610

## **Consent for Treatment**

I give my consent to receive treatment from Kelly Ardieta LCSWR. I have received a copy of Client Rights and Responsibilities and I have had an opportunity to ask questions. I understand my rights and responsibilities and agree to abide by them as stated in this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_