Rochester Counseling Solutions
1344 University Ave Suite 230
Rochester NY 14610

Consent for Treatment

I give my consent to receive treatment from Robert Hawkes, LMHC. 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_____