

**EASTMAN COUNSELING SERVICES
RONALD J. EASTMAN, M.ED., LMHC, CGP
CONSENT FOR TREATMENT**

I hereby authorize Ronald J. Eastman, M.Ed., to provide treatment for myself and/or for the following minor(s) of whom I am the parent or legally constituted guardian:

Name: (please print)

Name(s) of minor(s): (please print)

I have received a copy of the client rights and disclosure statement (which includes information on the Counselor Credentialing Act, available services, fees, and payment expectations). I understand if I have questions I may speak to Ron Eastman.

I hereby agree to pay for counseling sessions at the time such services are rendered unless other arrangements have been made in advance.

Client Signature: _____ Date _____