

HOPE IN HOME COUNSELING, LLC

727-612-3343/ kathleen@hopeinhomecounseling.com

Consent for Treatment

I, _____ parent/guardian of _____
(Name of Parent/Guardian) (Name of Child)

agree to treatment of counseling with Kathleen Rodriguez, LCSW of HOPE In Home Counseling, LLC.

Signature _____ Today's Date _____
(Signature of Parent/Guardian)