RON LEONARD, PCC
19126 Ravenna Road (SR 44)
Auburn, OH 44023
440-781-7323

THE FOLLOWING INFORMATION SHEETS HAVE BEEN GIVEN TO ME AND I HAVE READ THEM. IF I AM NOT SATISFIED WITH ANY PART OF THE INFORMATION GIVEN IN THE SHEETS, I WILL BE ABLE TO DISCUSS THIS FURTHER WITH THE THERAPIST OR TO REMOVE MY SIGNATURE FROM THIS SHEET. THE SIGNATURE SHEET REMAINS IN EFFECT FOR ONE YEAR FROM MY DATE OF SIGNING. I ALSO AGREE TO TREATMENT BY CLINICIAN, RON LEONARD, PCC.

CLIENT NAME (PRINT)_____

1. I have read the INFORMED CONSENT DISCLOSURE STATEMENT and have received a copy of it. I understand the limits of confidentiality.

   _____

2. I have read and received a copy of the FINANCIAL POLICY. I understand and will adhere to the policy.

   _____

3. I have received a copy of the CLIENT RIGHTS & RESPONSIBILITIES statement.

   _____

_____ _____
CLIENT SIGNATURE DATE