**Authorization for Evaluation and Treatment of Adults**

Client Name:

I authorize Teri Martin Crabtree, LPC-MHSP to provide counseling services to ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Such treatment may include but is not limited to individual counseling, group counseling and family counseling, or other specialized counseling procedures which are generally accepted in the treatment of adult mental health. My signature validates my consent to receive treatment from Teri Martin Crabtree, LPC-MHSP.

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**Client Signature Date**