Treatment Plan Signature Page

I/We (client/guardian) have actively participated in the development of this treatment plan and understand the treatment goals and objectives listed. I have the following comments/response:

_____

_____

_____

_____

_____

We ☐ Agree ☐ Disagree with this treatment plan.

☐ I have received/been offered a copy of treatment plan.
☐ I understand I may receive services from any qualified clinician/provider at Circle of Care.

Client: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

Relationship to Client: _____

Unable to sign, document reason: _____

TREATMENT TEAM:

LMHP Signature, Degree / License: _____ Date: _____

MHP Signature, Degree / License: _____ Date: _____
**If MHP is under supervision for licensure, then LMHP signature needed*