Patient #: _____

****Please scan into EMR****

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TREATMENT PLAN SIGNATURE PAGE

Patient Name:	**Date of Birth:**

Staff and Client or Parent/Legal Guardian sign below whenever the plan is implemented/reviewed/revised.

Date	**Staff Signature**	**Date**	**Client or Parent/Legal Guardian Signature** I have had input into the plan as described in my electronic medical record note. This plan has been verbally reviewed with me and I agree with my plan. Whereas treatment recommendations related to goals will be adjusted and/or made at each visit I understand that a more comprehensive review of the treatment plan will occur at least annually. I choose the providers as indicated in my plan.