Please scan into EMR

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TREATMENT PLAN SIGNATURE PAGE

Patient Name:		Patient Number:	
		Insurance #:	
		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	
2	2. S.	2	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.