Name: _____
DOB: _____
Record/Alpha Number: _____
Medicaid/Ins. Number: _____

Treatment Plan Signature Page

I have participated in the assessment and development of the crisis plan, as necessary, and the treatment plan. I agree with the goals and services/supports to be provided.

I am willing to participate in the recommended frequency of sessions.

I understand the treatment plan will be reviewed/updated and I will give input on progress and/or concerns.

This signature page serves as the order for services verifying that services have been deemed medically necessary by the rendering provider.

Date	Client/Guardian/Clinician Signature	Title