***Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Review:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***TREATMENT PLAN & REVIEW SIGNATURE PAGE***

*My signature below means that I have participated in the formulation of this treatment plan, understand, and approve of it, and accept the responsibility to carry out my part of the plan actively. I understand the need for services and each element of the treatment plan as presented. I understand this plan will be reviewed at least every 90 days or as requested if needs change. I understand I have a right to receive a copy of the plan and have been offered a copy of the plan. As the identified client, I acknowledge the right to choose my provider and agree to the current providers assigned.*

*(This is a strictly confidential patient medical record. This report reflects the patient’s condition at the time of consultation or evaluation. It does not necessarily reflect the patient’s diagnosis or condition at any subsequent time.)*

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|  |  |  |
| **\*Signature of Client** |  | **Date** |
|  |  |  |
| **\*Signature of Legal Guardian (if minor/incapacitated person)**  *Verbal consent was obtained from the legal guardian.* |  | **Date** |
|  |  |  |
| **\*Signature of QMHP: Name, Credentials**  Developed plan |  | **Date** |
|  |  |  |
| **\*Signature of Clinical Supervisor: Name, Credentials**  Same as QMHP signature above |  | **Date** |
|  |  |  |
| **Other Participant (Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |  | **Date** |
|  |  |  |
| **Other Participant (Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |  | **Date** |
|  |  |  |
| **Other Participant (Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** |  | **Date** |