OUTPATIENT SERVICES
INDIVIDUAL TREATMENT PLAN CONSENT

Client Name: _____ **DOB:** _____
INS/MA: _____

My signature indicates that I have participated fully in the development of my individual treatment plan. I also understand that I may appeal the treatment recommendations, content, or interventions at any time by expressing my concerns to my provider in writing.

CLIENT SIGNATURE	**DATE**
PARENT/GUARDIAN SIGNATURE (IF APPLICABLE)	**DATE**
THERAPIST SIGNATURE	**DATE**
PSYCHIATRIST SIGNATURE	**DATE**
OTHER SIGNATURE	**DATE**