**TRUE Mental Health & Wellness, PLLC**
***Trust. Rapport. Understanding. Encouragement.***
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# TREATMENT PLAN AGREEMENT

Date of Plan:_____

Patient Name:_____

Date of Birth:_____

MRN:_____

Insurance:_____

I agree with the Treatment Plan described in the progress note for the date above.

- I agree with this Treatment Plan. _____
  (Patient Signature) (Date)

- I agree with this Treatment Plan. _____
  (Legal Representative, if applicable) (Date)

  _____
  (Printed name & relationship to patient)

- If agreement obtained by telephone, phone number:_____

  _____
  (Witness #1) (Date)

  _____
  (Witness #2) (Date)

_____
(Clinician Signature/Title) (Date)