

Counseling Connections of SA Treatment Plan Signature Page

Client Name _____ DOB _____

PRINT

By signing below I am acknowledging that I have reviewed a copy of my treatment plan and agree with the plan as well as service recommendations to be coordinated by Counseling Connections of San Antonio. I am also committing myself to achievement of the goals listed within this service plan to the best of my ability in cooperation with the treatment team members signed below.

Treatment Service Plan: Start Date: _____ End Date: _____

CHECK ORDERED SERVICES:

_____ Community Support Diagnostic Assessment
_____ Refer for Psychological Testing
_____ Treatment Court Service Ordered

Family Outpatient Services:

_____ Family/Conjoint Counseling

Group Outpatient Services:

_____ Group Counseling

Individual Outpatient Services:

_____ Individual Counseling

_____ Treatment Service Plan Development

Admitting Diagnosis: (Diagnostic DSM5 coding REQUIRED)

Axis 1 Primary: _____ **Axis 1 Secondary:** _____

* Note: Diagnosis given on or before the date the Supervising Clinician (if applicable) has signed this form.

Print Name (Client) Client Signature Date

Print Name & Credentials Clinician Signature & Credentials Date

Legal Guardian Printed Name Legal Guardian Signature Date

R. Keith Franklin, PhD, LPC-S

Clinical Supervisor Print Name/Credentials Signature & Credentials Date

Other Printed Name Other Signature Date

Referral for services outside Counseling Connections of San Antonio
(Please indicate any referral made to outside resources on behalf of client)