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
______Refer for Psychological Testing
______Treatment Court Service Ordered

X_____Diagnostic Assessment

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)