



## Treatment Plan Consent

Client Name: \_\_\_\_\_

NWMHC Provider Name: \_\_\_\_\_

Service ID: \_\_\_\_\_

**Please indicate your relationship to the client.**

- Self
- Parent
- Legal Guardian
- Conservator Health Care Agent/Health Care Power of Attorney

**Authorized Signature:** \_\_\_\_\_

**My signature indicates that I am legally authorized to sign.**

**Date:** \_\_\_\_\_