Northwestern Mental Health
Promoting Wellness, Instilling Hope

TREATMENT PLAN CONSENT

CLIENT INFORMATION
Date of Birth: _____

Legal Name:
First Name _____ Last Name _____

Preferred Name:
First Name _____ Last Name _____

Service ID: _____

ATTENTION: This is a legal document. Please read carefully.
By signing, you agree that you understand and accept the terms in this form.

- If the client is 18 years of age or older, the client must sign and date the form.
- If the client is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
- If the client is 17 years of age or younger the client's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

Please select one:
☐ I am 18 years of age or older and will be signing this form
☐ Client is 18 years of age or older and is incapable of signing
☐ Client is 17 years of age or younger
☐ I am 17 years of age or younger, but can sign due to a legal exception

Print Name of Authorized Signee: _____
☐ Self
☐ Parent
☐ Legal Guardian
☐ Conservator Health Care Agent/Health Care Power of Attorney

Signature: _____
My signature indicates that I am legally authorized to sign.

Date: _____