Human Development Associates

TREATMENT PLAN

NAME ____ DATE ______/______/_______

Date of Birth ______/______/______

Briefly describe the problems or concerns that bring you into treatment:

What are your goals for treatment?

1. ____

2. ____

3. ____

Name of Primary Care Provider: ____

I consent to treatment at Human Development Associates. I understand that entering treatment is not a guarantee of results. This consent can be revoked at any time.

Signature ______________________________________ DATE ______/______/______

Parent/Guardian Signature (if minor) ____

- -- - - FOR STAFF USE ONLY -

Diagnosis Code ________________________________

Procedure Code ________________________________