ASPIRE NETWORK
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# ARMHS TREATMENT PLAN CONSENT

I,_____, give permission to the ARMHS practitioner to provide ARMHS services to me in my home, in the community, or the office for the projected amount, frequency, scope, and duration of the services and goals listed. I understand that I may revoke this consent at any time and this consent expires upon fulfillment of the above-stated goals or six months after the signature date, whichever comes first. Therefore, by signing below, I consent that I have received a copy of the treatment plans as outlined in the electronic health record. As my treatment plan is a working document, I understand that I can change or revise the treatment plan anytime I choose.

I acknowledge that I received a copy of the treatment plan on this date.

Signed:_____ Date: _____
Client

Signed:_____ Date:_____
MHP/Therapist/Skilled Worker