Restore Outreach Center
3966 Warrensville Ctr. Rd.
Phone: 440-340-5086
Fax: 440-340-5286
oh@restoreoutreachcenter.com

Treatment Plan Consent Form

Client Name	DOB
Record Number	

Treatment Plan Consent

I understand that Mental Health Services are provided by independently licensed counselors', and counselor trainees under supervision and that the independently licensed counselor will review treatment plans and sign appropriate forms for payment. Restore Outreach Center offers no guarantees or positive assurances regarding the outcomes of the therapeutic services.

I have received a copy of and understand the Notice of Privacy Practices, a written summary of the Federal laws and regulations regarding confidentiality of client records as required by 42 CFR Part 2. I understand that I have the right to discuss my concerns, complaints, or grievances with any staff member from the ROC who is involved in my care.

I also have the right to file a grievance with the ROC or as indicated in the Client Rights information that I have received.

TREATMENT PROVIDED:

☐Assessment ☐Treatment Plan ☐Mental Health Counseling
☐CPST ☐TBS/PSR ☐Group Counseling

Potential benefits and risks have been explained to me. I hereby give my consent to Restore Outreach Center, LLC for the above checked services, as applicable.

Client/Legal Guardian	Date:
Clinician Signature	Date:
Supervisor Signature	Date: