Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

Client Name: _____ Client Age: _____
Date Completed: _____ Start Time: _____ Stop Time: _____

SERVICE PLAN SIGNATURE PAGE

CLIENT ACTIVE PARTICIPATION STATEMENT: I/We (client/guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I have the following comments/response:

_____

_____

_____ _____
Member Signature, **12 or older** Date Parent/Guardian Signature Date

***Adult members: Has the Treatment Plan Advocate form been completed and signed? ☐Yes ☐No**
Has the Advanced Directive/Living Will form been completed and signed? ☐Yes ☐No
(Attach to signature page and submit together – required by OHCA and ODMHSAS)

If unable to legibly sign, document reason:_____

_____
Responsible LBHP Signature, Degree/License/Under Supervision Date

_____
Agency Supervising LBHP Signature & Credentials Date

TREATMENT TEAM:

Service Type	Treatment Methodology	Frequency of Service(Week/Month)	Provider Name & Credentials
Individual Therapy	_____	_____	_____
Group Therapy	_____	_____	_____
Family Therapy	_____	_____	_____
Rehab-Individual	_____	_____	_____
Case Management	**refer, link, monitor, advocate, follow-up**	**up to 12 units/mo**	_____
Telehealth	_____	_____	_____
Other	_____	_____	_____

For Office Use Only:

 Logged: _____ Treatment Team Verified: _____

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Client Name: _____ Insurance ID #: _____

Treatment Advocate Form

All adult clients receiving mental health and/or substance abuse services have the right to name a family member or other individual as a Treatment Advocate. Each consumer has the right to determine the level of involvement and decision given to the Treatment Advocate, and there will be no limitation preventing communication or collaboration between the client and their Treatment Advocate. The consumer may revoke this designation at any time, and for any reason.

Would you like to name a Treatment Advocate? ☐ **Yes** ☐ **No** **(Must select one)**

Please provide the following information to establish your Treatment Advocate:
Name: _____
Address: _____
Phone Number: _____
E-mail Address: _____

Please initial the level of involvement you would like to establish for your Treatment Advocate"
☐ **Attend intake/assessment sessions**
☐ **Assist with treatment planning**
☐ **Receive written copies of the treatment plan**
☐ **Attend therapy sessions**
☐ **Access to Medical Records**
☐ **Other:** _____
_____
_____

_____ _____
Client Signature Date

*Treatment Advocate:
I, _____ agree to serve as the Treatment Advocate for the above named client. I agree to comply with all confidentiality obligations and will only serve in the capacity stated above by the client.

_____ _____
Treatment Advocate Signature Date

Advance Directive for Health Care

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

(1) If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

____ See my more specific instructions in paragraph (4) below.

(2) If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

____ See my more specific instructions in paragraph (4) below.

(3) If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration

____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

____ See my more specific instructions in paragraph (4) below.

(4) OTHER. Here you may:

(a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn,
(b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or
(c) do both of these:

_____

_____

_____

_____

_____
Initial

II. My Appointment of My Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of _____, whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint _____ as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

____ transplantation

____ therapy

____ advancement of medical science, research, or education

____ advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. If I initial the "yes" line below, I specifically donate:

___ My entire body

Or

___ The following body organs or parts

___ Lungs	___ Liver
___ Pancreas	___ Heart
___ Kidneys	___ Brain
___ Skin	___ Bones/Marrow
___ Blood/Fluids	___ Tissue
___ Arteries	___ Eyes/Cornea/Lens

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.
b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
e. This advance directive shall be in effect until it is revoked.
f. I understand that I may revoke this advance directive at any time.
g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this ____ day of _____, 20 ____.

_____
(Signature)

_____
City of

_____
County, Oklahoma

_____
Date of birth (Optional for identification purposes)

This advance directive was signed in my presence.

_____
Witness

_____, Oklahoma
Residence

_____
Witness

_____, Oklahoma
Residence