Regent Mental Health Group, SC

700 Rayovac Dr Ste 103, Madison WI 53711
Ph: 608-238-5826 Fax: 608-238-1221

Treatment Plan Acknowledgement Agreement

_____ _____

Patient's full name **Patient's DOB**

Appointment review date: _____

Provider name: _____

My signature below indicates:

- I have been offered copies of my treatment plan as detailed by my provider in my session; and
- *(If applicable)* I have been informed about any medications prescribed as part of this treatment plan and their possible side effects.

_____ _____

Signature of patient (ages 14 years or older) **Date**

_____ _____

Signature of legal representative for patient under 18 **Date**