

MIND-SET SOLUTIONS INITIAL TREATMENT PLAN

CLIENT	
NAME:	
DOB:	AGE:
SSN #:	
INSURANCE PROVIDER:	
Member ID #:	
GROUP #:	
BRIEFLY DESCRIBE REASON FOR REFERRAL or VISIT	
(e.g. infidelity, Frequent arguments, difficulty resolving problems, frequent misunderstandings, poor communication, or boundary violations)	
BRIEFLY DESCRIBE PROBLEM/SYMPTOMS	
(e.g. not speaking, sleeplessness, yelling, slapping, or hitting, increased depression, anxiety, stress, or sadness)	
BRIEFLY DESCRIBE YOUR DESIRED GOALS	
(e.g. Enhance trust, develop a loving marriage and partnership, develop positive communication style)	
CLIENT(s) /GUARDIAN SIGNATURES:	DATE:
CLINICIAN SIGNATURE:	DATE:

MIND-SET SOLUTIONS LLC

CONFIDENTIAL

Alternative Interventions INC.

By signing this document you agree to allow this initial treatment plan agreement to serve as authorization for your initial treatment plan and verbal permission for the development of a modified master treatment plan based on assessment outcomes and ongoing issues presented during the course of your treatment while utilizing a telehealth platform.