Services Prescribed:

☐ Individual/Family Therapy	60 minutes, 1x per week for 6 months	Carol Watler, LMHC
☐ Biopsychosocial Evaluation	1x per year	Carol Watler, LMHC
☐ Brief Behavioral Health Status Exam	1x for 30" per year	Carol Watler, LMHC
☐ Group Therapy	1x/wk for 55min each for 6 months	Carol Watler, LMHC
☐ Psychiatric Evaluation	1x at admission	Dr. Pham Phuoc, Psychiatrist
☐ Medication Management	1x/month for 30 min each for 6 months	Dr. Pham Phuoc, Psychiatrist

Anticipated Aftercare Needs: _____

_____

Signatures:

Client _____ Date: _____

Parent/Guardian _____ Date: _____

Therapist _____ Date: _____

I certify that the services on this treatment plan are medically necessary as prescribed for this client's diagnosis and treatment needs.

_____ _____

Treating Licensed Practitioner of the Healing Arts Date

_____

Treating Licensed Practitioner of the Healing Arts Printed Name & Credentials