

Updated Telehealth Policy Form Please fill out, ,sign and date

08/21/23

Elizabeth A Smith LCSW

Phone 480 294-4581

Client's full name \_\_\_\_\_

Client's address ----street-no.----- Street

- name ----- City-----State----- zip code-----

In case of emergency the therapist will need to know the client's full physical address. and a emergency contact person

name -----phone no \_\_\_\_\_contact person

If the technical connection gets interrupted the therapist will call you back shortly

The telehealth session will be on a HIPPA compliant platform.

Please ask any questions before signing

Thank you.

Elizabeth Smith LCSW

Client signature \_\_\_\_\_ - Date \_\_\_\_\_