Hope for Tomorrow Counseling

AUTHORIZATION FOR FACE-TO-FACE COUNSELING

During the Covid-19 Emergency Period

Based on my professional assessment, the client

NAME: ___________________________________ DOB:_________________

Dx: ____

requires face-to-face counseling as the most appropriate delivery of services. Telehealth counseling would not be the best practice in this case because of:

[ ] mental health risk

[ ] therapeutic need

[ ] it is not logistically feasible

[ ] they are a new client

Comment: *(in a sentence describe the condition making face-to-face counseling necessary)*

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Clinician: ______________________________________ Date: _________________

Signature

Authorized by

Director: _______________________________________ Date: _________________

Signature