Telehealth Agreement

Service Provider Information

Dr. Kim Sunseth, PhD CPsych
Office Address:
158 Brant Rd., St. George, ON N0E 1N0
Phone:
519-414-9444

Patient Information

Name (please print):

____

Address:

____

____

Email (if applicable):

____

Phone, as required for Service(s): (999)999-9999

____

Other account information required to communicate via the Service(s):

____

I, ____, acknowledge that I am consenting to have Dr. Kim

(Insert Patient Name)

Sunseth (the Service Provider) communicate with, and/or provide services through email (reminders) and

Adracare videoconferencing , ____

(Insert name of media here [email, text, social media, videoconferencing, etc.])

As of this date: ________________________________, I am aware of the following:

____

____

Patient Signature: ____

Date: ____