



Coastal Haven Counseling, LLC
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Telehealth Individual Plan of Care Authorization Form

This consent authorization acknowledges that I will be participating in telehealth with Coastal Haven Counseling, LLC. I understand during my initial appointment my therapist and I will discuss my goals for my Individual Plan of Care, at which time I will have the opportunity to ask questions regarding my treatment. Further, my signature below gives Coastal Haven Counseling, LLC. permission to attach this as my consent to my Individual Plan of Care.

Client Full Legal Name - PRINT

Client/Parent or Guardian (if applicable*) Signature

Date

*if client is under the age of 18, parent or guardian signature required