PADMA Counseling, PLLC
(210) 802-8758

2. Informed Consent for Telehealth Treatment

General Information

Telehealth is live, two-way, audio and video electronic communication that allows counselors and clients to meet outside of a physical office setting.

Client Understanding and Agreement

I understand that benefits of telehealth may include but are not limited to increased accessibility to services, flexibility in scheduling, and privacy and comfort in choosing my own setting(s) for sessions.

I understand that my counselor will conduct telehealth sessions over a HIPAA-compliant platform called Ensora Health, and she will establish a video conference session that I will access through my TheraNest client portal. I understand that it is my responsibility to ensure that I have access to my Ensora Health client portal prior to each telehealth session.

I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not guaranteed to be 100% secure.

I agree that the counselor (Cynthia Y. Chi, MD, MS, NCC, LPC) and practice (PADMA Counseling, PLLC) will not be held liable or responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand that none of the telehealth sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect the privacy and confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.

I understand that either I or my counselor may discontinue the telehealth sessions at any time if it is determined that the audio/video technology is not adequate for the situation. I understand that it is my responsibility to ensure that I have a reliable and consistent connection (e.g., via ethernet, WiFi, cellular) for my device.

I understand that if there is an emergency during a telehealth session, then my counselor may call emergency services and/or my emergency contact.

I understand that there are potential risks to this technology, including but not limited to interruptions, unauthorized access, and technical difficulties.

I understand that if the video conferencing connection drops while I am in a session, it is my responsibility to have an additional phone line available to contact my counselor or to allow my counselor to contact me. I understand that it is my responsibility to provide my counselor with a working phone number and to update this number as needed.

I understand that this form is signed in addition to the "Informed Consent for Counseling and Psychotherapy" and "HIPAA Notice of Privacy Practices" and that all practice policies and procedures apply to telehealth services.

I understand that telehealth services are completely voluntary and that I may withdraw this consent at any time for any reason by doing so in writing.

Attestation and Consent

My initials below and signature at the end of this document indicate that I 1) have reviewed this document in its entirety, 2) understand its contents and agree to its terms, and 3) have had my questions answered to my satisfaction. By initialing and signing below, I consent to telehealth treatment.

Client Initials:

Date Signed:

Client Full Name:

Client Date Of Birth: