



## Arlene C. Gerson, PhD

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### Telehealth Addendum

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

This addendum is provided to share information about telehealth services and obtain your consent for utilizing them. Telehealth services are services that are provided using communications technology rather than in person. You are not required to consent to telehealth services in order to receive services from Dr. Gerson.

1. **Benefits:** Telehealth services enable you to continue to receive services when transportation, distance, illness, or public health concerns make in-person appointments impractical.
2. **Risks:** Research on telehealth is evolving so the differences between in-person and telehealth visits are not fully known. Although I aim to maintain confidentiality, security breaches may occur just as with any other technology.
3. **Privacy:** Privacy limitations of your location (e.g. someone walks into the room you are in), distractions in your environment, and service disruptions may occur. Should an interruption occur we should call each other by telephone to communicate. You agree to ensure that you have a quiet, distraction-free environment, a secure working electronic device, and internet service in order to agree to telehealth services. You agree to inform Dr. Gerson and obtain agreement to continue session if someone walks into the room or should you desire to record any part of session.
4. **Safety:** Although rare events, emergencies do occur. I need to be able to know your physical location in the event of an emergency. You also must authorize me to share clinical information with at least one person who can assist in the case of an emergency. By writing their names on this form, you consent to release of your information in case of an emergency.
5. **Billing:** As with in person sessions, you are responsible for paying for sessions at the time of service. Many health insurance providers will reimburse telehealth services; however, this is not the case for all providers. You agree to be responsible for clarifying your insurance benefits prior to session.

Emergency contact 1: (name/phone number): \_\_\_\_\_

Emergency contact 2: (name/phone number): \_\_\_\_\_

I understand and agree to abide by these telehealth policies. I will ask Dr. Gerson any remaining questions I may have, (e.g., what to expect from therapy, scheduling, special arrangements, etc.).

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_