Dr. Gia Marson Psychologist
310-526-3123
www.drgiamarson.com

1452 26th Street, Suite 301
Santa Monica, CA 90404
90265

Malibu Vista at Carbon Beach, Suite 118
22809 Pacific Coast Hwy, Malibu CA

Welcome to my private practice.

I consider it a privilege to work together as you take this opportunity to reach your goals. At our first appointment, we will have the opportunity to have a conversation about where you are now and where you would like to be. If we agree to work together, we will develop a plan to help you reach those goals. These following pages ask for your contact information, clinical and payment information. They also provide a description of my office policies and consent for treatment, confirmation that you have reviewed the notice of privacy and consent for telemedicine (should you ask for a remote session). Lastly, I have included a Release of Information page for providers with whom you are already working to enable collaborative care and best practices. These are meant for your careful review, completion and signatures. I appreciate that your time is valuable and want to preserve our first appointment for in-person conversation. Respectfully, I ask that you print and complete these required documents, then bring them to our first appointment. *If your physical address, email or phone contact information changes while we are working together, please notify me so I can update the records.*

If you are a minor or the parent of a client who is a minor, please notice the forms require signatures from both a parent or guardian and the minor. In addition, please review the HIPAA Notice of Privacy Practices. The HIPAA Notice of Privacy Practices is in a separate file on my website, www.drgiamarson.com and on paper at my office. Feel free to print out the HIPAA forms as well or to request your own paper copy from me.

The fee for my professional service is $300.00 per hour (which is 50 minutes for therapy appointments) due at the time of service. 90 minute appointments are $450.00. By special arrangement and in some circumstances of financial hardship, a sliding scale may be possible to arrange. If we cannot make this arrangement I will identify community referrals for you. Payments can be made by check, cash, credit or debit card at the time of the appointment. Please include credit card information on your intake form. When you sign the treatment form, you are consenting that your credit card will be charged for missed sessions, for appts cancelled with less than 48 business hours notice or any balance that extends past one month. You will never be charged for cancellations due to illness regardless of timing. Through the mail, you will receive a statement each month for your records and to seek insurance reimbursement. For your convenience and privacy, I use an electronic medical record. Using your own email address, you can use a secure login & password through which to communicate, check appointments, and update your contact information. If you prefer not to communicate electronically, feel free to call me at my office 310-526-3123. Calls are typically returned within 24 business hours M-F unless I am out of the office.

In Santa Monica Suite #301 is located in the cottage behind the main building. Bathrooms & water cooler are available in the main building. Go out the back door to reach the cottage. There is a call light next to my office door. Flip it so I know you've arrived. There is metered street parking. In Malibu Suite #118 is located on the first floor of the office building above the garage. Check-in with reception on the second floor when you arrive. Il will meet you there. Bathroom keys are available at the reception desk. Free visitor parking is available under the building. Check with me for the gate code to the garage and building (as they change frequently). These forms, policies, practices and questionnaires are meant for your information, for me to gather some basic information before we meet in person and to answer potential questions.

**Please read all of the attached forms about office policies, consents and the HIPAA Notice of Privacy Practices on my website at www.drgiamarson.com. Kindly complete, sign and return the following pages before or at your first appointment:*

- ❑ *Contact & Payment (#2)*
- ❑ *Clinical Information (# 3)*
- ❑ *Consents (#4)*
- ❑ *Release of Information (#5)*

I always welcome the opportunity to answer all of your questions in person or over the phone. I look forward to working together collaboratively!

Warmly, Dr. Gia Marson

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Contact and Payment Information

Legal Name _____ Preferred name_____
Today's date: _____
Preferred pronoun_____ Language(s) you speak_____
Religious affiliation_____ Ethnicity _____ Country of origin_____
Birthdate _____
Referred by _____ May I thank the person who referred you? Yes No
Home Address
_____
Mailing Address for billing statements (if different from home address)
_____

Phone and Email Contacts
Cell _____ Home _____Work _____

Email _____ *email or text* for scheduling? _____
If you are under 18 years old, please complete parent questions.
Name of parent(s) or guradian(s)
_____ Cell _____ Email _____
_____ Cell _____ Email _____

Emergency contact name _____ Relationship to you_____Cell _____
With whom do you live? _____Marital/partner status _____
Do you work? *part-time* or *full-time* ttend school? *part-time or full-time* Where _____

Who are your current providers?
Psychiatrist _____ Phone # _____
Primary care physician _____ Phone # _____

Payment Preference
Cash _____ Check _____ Credit card _____

Credit Card information: Please provide credit card information to be used for payments to cover appointments (if you prefer), and to cover missed appointments or balances that extends beyond one month.
Name on card: _____ Billing address for this card _____
Card #_____Exp Date _____ cvv code_____

Your signature below authorizes this card to be used for payment unless other payment is made at the time of service:
Name: _____ Date_____Signature _____

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Clinical Information

1) How would you describe what is bringing you in at this time?

_____
_____
_____

2) What symptoms or problems are most concerning to you or those who care about you?

_____

3) When did you first notice the problem? How often does it occur?

_____

4) What is motivating you to change?

_____

5) What have you already tried?

_____

4) Are you currently taking any medications? (Circle answer) Yes No
If yes, please current list medications, dosage and purpose below.
Medication _____ dosage _____ purpose _____ Medication _____ dosage _____ purpose _____
Medication _____ dosage _____ purpose _____ Medication _____ dosage _____ purpose _____

5) Do you have any serious or chronic medical conditions? (Circle answer) Yes No
If yes, please explain. _____

6) Have you had any serious medical accidents or conditions in the past? (Circle answer) Yes No
If yes, please explain. _____

7) Have you or anyone in your family ever been suicidal or made a suicide attempt in the past? (Circle answer) Yes No
If yes, please explain. _____

8) Have you experienced any significant loss or trauma? (Circle answer) Yes No
If yes, please explain. _____

9) Do you have a substance abuse problem or have you had one in the past? (Circle answer) Yes No

If yes, please explain. _____
Do you attend a 12-step program? (Circle answer) Yes No If yes, which one? _____
If no, how many days per month do you use: alcohol _____ nicotine _____ marijuana _____ other drugs _____

10) What are your hobbies? _____

11) What are your strengths? _____

12) Do you exercise regularly? (Circle answer) Yes No
If yes, please explain. _____

13) What do you do to relax? _____ What do you do for fun? _____

14) Do you have close friends? (Circle answer) Yes No Who do you lean on for support? _____

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Consent to Treatment

Acknowledgment and Agreement for Informed Consent:
My signature below indicates that I have read the above office policies and consents, and agree to abide by these terms during my professional relationship with Dr. Marson.
The undersigned client (or responsible party such as parent, legal guardian) consents to and authorizes services by Gia Marson, Ed.D. which may include evaluation, psychotherapy and referrals for medical or medication evaluations.
The undersigned understands that they have the right to:
Be informed of and participate in the selection of treatment modalities. Discuss, change or review your treatment plan. End therapy at any time and ask for referrals.
Receive a copy of this consent.
Withdraw this consent at any time.
I have read and understand the information provided about office policies, payment and consent for therapy. My signature below is an indication of my agreement.

Name: _____ Date_____ Signature _____

*If you are under 18yo, please have your parent/guardian/conservation complete this portion below to consent

Name: _____ Relationship _____ Signature _____

Acknowledgment of Review and Receipt of Notice of Privacy Practices

It is required by law that you read the Notice of Privacy Practices on Dr. Marson's website www.drgiamarson.com or the paper version in her office. I have read and understand the information provided about privacy practices.

Name: _____ Date_____ Signature _____

*If you are under 18yo, please have your parent/guardian/conservation complete this portion below to consent

Name: _____ Relationship _____ Signature _____

Telemedicine Consent

I have read and understand the telemedicine information provided in this paperwork. I have discussed any questions with Dr. Marson and they have been answered to my satisfaction.My signature below is an indication of my agreement.

Name: _____ Date_____ Signature _____

*If you are under 18yo, please have your parent/guardian/conservation complete this portion below to consent

Name: _____ Relationship _____ Signature _____

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Release of Information: Authorization for Use and Disclosure of Confidential Information (HIPAA and CA Law)

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with the CA Law and Federal Law concerning privacy of such information. All information must be provided for this authorization to be valid.
Use and Disclosure of Health/Mental Health Information
Client's name _____ Date of birth _____

My therapist, Dr. Gia Marson is authorized to (check all that apply)
_____ Release or disclose records and/or information to
_____ Obtain or use records and/or information from
_____ Mutually discuss and exchange records and/or information

This information should only be released to:
_____
Contact this provider/entity by (phone) _____ (email) _____

Specific Information to be Released/Obtained (Please select only one)
_____ All health/mental health information including diagnosis and treatment received

_____ Only the following records or type of information _____

Please specify if any information is to be excluded: _____

This disclosure of information authorized by Client is required for the following purpose
_____

This authorization shall become effective immediately and expire in one year. A copy or fax is considered as valid as the original.
Please note: If you have authorized the disclosure of your mental health/health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. CA Law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law. our Rights:
You may refuse to sign this authorization.
You may revoke this authorization by delivering your revocation in writing to me at my office (see address above). However, this revocation will be effective when I receive it and will not extend back to information that was already obtained or released (used or disclosed) prior to the revocation.
You have a right to receive a copy of this authorization.
You may inspect or obtain a copy of your mental health information within the limits of CA and federal laws.
Neither treatment, payment, enrollment or eligibility for benefits will be conditioned upon your providing or refusing to provide this authorization,
I have read and understand the information provided above. I have discussed it with Dr, Marson, and all of my questions have been answered to my satisfaction. If signed by other than client, please indicate your relationship.

Name: _____ Date_____ Signature _____

*If you are under 18yo, please have your parent/guardian/conservator complete this portion below to consent

Name: _____ Relationship _____ Signature _____

If you no longer wish to authorize this release of information, please complete the portion below and bring it to me at our next appt. I am hereby revoking this authorization:

Name: _____ Date of revocation _____ Signature _____

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Office Policies

It is required by law that you read the Notice of Privacy Practices on Dr. Marson's website www.drgiamarson.com or the paper version in her office.

Dr. Marson is a licensed psychologist and regulated by the California Board of Psychology.

Payment is due at each session and may be made by cash, check or credit card.

A credit card is kept on file for missed sessions and unpaid sessions.There is no charge for a missed session if you cancel because you're sick.

Dr. Marson can offer sessions through telemedicine by audio or video as appropriate. Please sign consent for telemedicine so it is on file in case the need should arise.

Therapy may be terminated by you or Dr. Marson at any time for clinical or financial reasons. If therapy is terminated before your goals are reached, referrals will be provided.

If Dr. Marson is required to attend a deposition, hearing or other legal proceedings in the capacity of current or past mental health care, services will be billed at her current rate, including preparation and travel time as well as the time she spends at the legal proceeding. Dr. Marson's testimony will not include any forensic opinions. Dr. Marson strongly prefers not to be part of any litigation even on a client's behalf in order to protect confidentiality and the privacy of your mental health record.

Telephone calls exceeding 15 minutes will be billed on a pro rata basis, based on the 50-minute session fee.

Eating Disorder Treatment

For clients with eating disorders, Dr. Marson works within a multi-disciplinary team as appropriate. This may include a medical doctor, registered dietitian, psychiatrist, parent(s) of a minor or other specialists. Dr. Marson does not charge for these communications. However, I do request that you are willing to allow me to communicate with all relevant providers so we are able to offer you collaborative, comprehensive, best practices for your healthcare. Feel free to ask for referrals.

Psychiatry

If you are meeting with a psychiatrist, Dr. Marson will not charge for collaborating on your behalf. However, I do request that you are willing to allow me to communicate with your psychiatrist so we are able to offer you collaborative comprehensive, best practices for your healthcare. Feel free to ask for referrals.

Insurance

Dr. Marson is not a member of any insurance panels.

Some health insurance plans will reimburse a portion of fees paid for out-of-network service.

Please consult with your insurance carrier in advance.

Canceled or Missed Appointments

Scheduled appointments are held for you. If you are unable to keep your appointment, kindly give ***48 business hours*** notice to avoid being charged the full rate for your reserved time. For Monday appts, please cancel by Friday at 8am.

- ➔ There is no charge when cancellation is due to sickness. If you are sick, please cancel in advance and specify that you are sick.

Phone, Email, Text Messages and Reminders

Voicemail messages from current clients left during business hours will usually be returned in 24 business hours.

Messages left on evenings, weekends and holidays will be returned within two business days.

In the event of an emergency, go to the nearest emergency room or call 911.

Email communication is inherently non-confidential. By communicating with Dr. Marson via email, you are accepting privacy risks.

Email communication is not recommended for clinical matters and is not appropriate for urgent issues or emergencies.

All communication with Dr. Marson may become part of your medical record.

Most clients prefer to have appt reminders sent via email or text. You can opt out of this service. Please communicate with me at our first appt or anytime after to stop appt reminders.

Confidentiality

The content of sessions is confidential except in certain situations including, but not limited to: cases where a client may be a danger to self or others; cases of suspected child, elder abuse or reports of a person viewing child pornography; cases where a patient may be incapable of taking care of him/herself; certain legal proceedings when required by a judicial subpoena.

Medical records are confidentially maintained and are not released without your written authorization.

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Telemedicine Policies

I may choose to engage in telemedicine with Gia Marson, Ed.D. for psychotherapy.I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

Because of recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and client. Without this information, tele-therapy may be slower to progress or less effective. With the telephone/audio, the client’s tone of voice, pauses and choice of words become especially important and therefore an important focus of the sessions. What is important here is that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy.

If Dr. Marson has not met you in person, she may request that you be interviewed by a professional in your area and allow her to talk to that individual before proceeding with therapy. With tele-therapy, there is the question of where is the therapy occurring – at the therapist’s office or the location of the client? The law has not yet clarified this issue, therefore it is Dr. Marson’s policy to inform clients that they are receiving services from my office (as if they were physically traveling to Santa Monica or Malibu) and therefore are bound by the laws of the State of California. These laws are primarily related to confidentiality as outlined in these office policies..

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. (2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent. (3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Marson, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if Dr. Marson believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. (4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. (5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.