Dr. Gia Marson

Psychologist

Malibu | Santa Monica

310-526-3123

www.drgiamarson.com

General inquiries: info@drgiamarson.com

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 all documents, then bring them to the office, mail or email them to me securely. 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 can be downloaded or reviewed at any time online at www.drgiamarson.com. Feel free to request a paper copy.

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 and to pay for 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 if you choose to do so.

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 and emails are typically returned within 48 business hours M-F unless I am away from the office. Kindly complete, sign and return the following pages before or at your first appointment:

- ❏ Contact & Payment
- ❏ Clinical Information
- ❏ Consent Forms

In any emergency, please seek emergency services by calling 911 or go to your nearest emergency room. I welcome the opportunity to answer all questions now and should any arise in the future. 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 # ________________________

Place a checkmark next to your preferred payment method.
Cash _____ Check _____ Credit card _____ Zelle to drgiamarson@gmail.com _____

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 and General Office policies

My signature below indicates that I have read the Gia Marson, Ed.D.'s 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 understanding and 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 provided to you. You may also review and download them online at www.drgiamarson.com or request a paper version be provided to you.

I have read and understand the information provided about privacy practices. My signature below is an indication of my understanding and 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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Telemedicine Consent:

I have read and understand the information provided about telemedicine policies. My signature below is an indication of my understanding and agreement.

Name: ____ Date____________

Signature ____

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

Name: _______________________________ Relationship ______________________

Signature ____

Consent to In-person Appointments during Covid-19:

I have read and understand the information provided about in-person sessions during the pandemic. My signature below is an indication of my understanding and agreement. My signature below indicates that I understand the policies, practices and precautions and that I agree to them.

Name: ____ Date____________

Signature ____

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

Name: _______________________________ Relationship ______________________

Signature ____