Dr. Gia Marson
Psychologist
Malibu | Santa Monica

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. I have been licnesed (PSY18764) in California since 2002.

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 payment 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 (page 2)
- ❏ Clinical Information (page 3)
- ❏ Consent Forms (page 4 & 5)
- ❏ Release of Information: Authorization for Use and Disclosure of Confidential Infor. (page 6 & 7)

You can find General Office Policies and Practices for your review on pages 8-18.

In an emergency, please seek emergency services by calling 911 or go to your nearest emergency department. I welcome the opportunity to answer all questions now and when they 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 _____

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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(Lic No Psy18764) 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 telephone at: _____
or by email at: _____

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
_____
_____

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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.

Your 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 anyone other than the 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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As a licensed psychologist (Lic No Psy18764), I have a responsibility to be clear about your rights and how those relate to the policies and practices in the law and at my office. On the following pages please find notices describing the policies and practices related to your treatment and care.

It is required by law that you read each one so you understand your rights. Please review them carefully and printe them out for your records. If you have any questions or would like to that Dr. Marson provide you with a paper copy, please call 310-526-3123 or contact online at www.drgiamarson.com. I respect your time.

Your consent will be requested in the intake packet for each notice

- General Office Policies
- Telehealth Policies
- HIPAA Notice of Privacy Practices
- Informed Consent for In-person Session during the Covid-19 Pandemic

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General Office Policies

This notice describes the policies and practices of our office. Please review it carefully. If you have any questions about this notice, please contact Gia Marson, Ed.D.(LicNo Psy18764) 310-526-3123 or online at www.drgiamarson.com. Dr. Marson is a licensed psychologist and is regulated by the California Board of Psychology.

Payment
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.
Telehealth
Dr. Marson may offer sessions through telemedicine by audio or video as appropriate.
Termination
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.
Outside of Office Appointments Billing
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. Letters or reports usually take one clinical hour.
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, we do request that you are willing to allow communication 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 and consider how the insurer will handle issues of your privacy and inquiries about diagnosis etc.

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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 and text communication are inherently non-confidential. By communicating with Dr. Marson via email or text, you are accepting privacy risks. Neitherl communication is not recommended for clinical matters and never appropriate for urgent issues or emergencies. If you have an emergency outside of your appointment, please call 911 or go to your nearest emergency room. 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 310-526-3123 or online at www.drgiamarson.com.

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

This notice describes the telehealth policies and practices of our office. Please review it carefully. If you have any questions about this notice, please contact Gia Marson, Ed.D. (LicNo Psy18764) 310-526-3123 or online at www.drgiamarson.com.

You may choose to engage in telemedicine with Gia Marson, Ed.D. for psychotherapy. Should you begin or continue therapy via telehealth, you consent to the following: you 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. You 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..

<u>You have the following rights with respect to telemedicine:</u>

(1)You 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 you would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, you 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 you make your mental or emotional state an issue in a legal proceeding.

You 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) You 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 your 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, You understand that telemedicine based services and care may not be as complete as face-to-face services. You also understand that if Dr. Marson believes you would be better served by another form of psychotherapeutic services (e.g. face-to-face services) you will be referred to a psychotherapist who can provide such services in your area. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite your efforts and the efforts of Gia Marson, Ed.D, your condition may not improve, and in some cases may even get worse.

(4) You understand that you may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) You understand that you have a right to access your medical information and copies of medical records in accordance with California law.

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HIPAA Notice of Privacy Practices

Effective Date: January 1, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Gia Marson, Ed.D. (LIcNo Psy18764) 310-526-3123 or online at www.drgiamarson.com. This notice describes the privacy practices at our office.

We are required by law to:

• Maintain the privacy of protected health information.
• Give you this notice of our legal duties and privacy practices regarding your health information.
• Follow the terms of the notice currently in effect.

How We May Disclose Your Health Information

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Gia Marson, Ed.D..

Treatment

We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment

We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations

We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services

We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care

When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research

We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law

We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety

We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates

We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans

If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Workers' Compensation

We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities

We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may release your health information in response to a request by a law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; or 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors

We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities

We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody

If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

Your Rights Regarding Your Health Information Right to Inspect and Copy

You have the right to inspect and copy your medical and billing records by written request to me.

Right to Amend

You have the right to request an amendment to your records by written request to Gia Marson, Ed.D..

Right to an Accounting Of Disclosures

You have a right to an accounting of certain disclosures by written request to Gia Marson, Ed.D..

Right to Request Restrictions

You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Gia Marson, Ed.D.. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Gia Marson, Ed.D. We will accommodate reasonable requests.

Changes to This Notice

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Gia Marson, Ed.D. or online at www.drgiamarson.com

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Informed Consent for In-person Sessions During Pandemic

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. By signing the consent form and coming in for in-person appointments, you are indicating that you understand and agree to these actions:

- ➔ You will only keep your in-person appointment if you are symptom free.
- ➔ You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
- ➔ You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.
- ➔ You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- ➔ You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.
- ➔ You will wear a mask in all areas of the office (I [and my staff] will too).
- ➔ You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff].

- ➔ You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- ➔ If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- ➔ You will take steps between appointments to minimize your exposure to COVID.
- ➔ If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know.
- ➔ If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know.
- ➔ If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth.
- ➔ I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing the consent form to meet face-to-face (on page #4), you are agreeing that I may do so without an additional signed release.