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

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

23622 Calabasas Road, Suite 320
Calabasas, CA 91302

January 1, 2018

Dear Client,

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. Then, if we agree to work together, we will develop a plan to help you reach those goals.

The following pages are meant for your careful review, for your completion and for your signatures. I appreciate that your time is very valuable and want to preserve our first appointment for more in depth conversation. Respectfully, I hope you can make time to print and complete these required documents, then bring them to our first appointment. If you prefer, I can leave paper copies of these forms at the office for you. In that case, please let me know and plan to arrive 15 minutes early. If your physical address, email or phone contact information change 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 a client who is a 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. Please be aware that the fee for my professional service is $250.00 per hour (which is 50 minutes for therapy appointments) due at the time of service. 90 minute intakes are $300.00 total. By special arrangement and in some circumstances of financial hardship a sliding scale may be possible to arrange. Payments can be made by check, cash, credit or debit card at the end of the appointment. Monthly, I will provide you with a medical spending statement receipt through the postal mail (or via email) with which you can 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 will be given a secure login & password through which to safely communicate, check appointments, and update contact information. Of course 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 on vacation.

It may be helpful to have some pertinent information about the offices:

In Santa Monica suite #301, is located in the cottage behind the main building. When you arrive at the address, walk through the main building in which you will find two bathrooms & a water cooler for your use, then go out the back door to the cottage. There is a call light next to my office door. Press it when you arrive. Family and friends may use the waiting room in the cottage or the main building. There is plenty of metered street parking. The cottage is across from Hulu and HBO (on Broadway), near Helen's Bicycles.

In Calabasas suite #320 is located on the 3rd floor. There are bathrooms on each floor of the building. When you arrive switch on the call light by my name. If there is an assistant at the desk, you may also check-in there if you wish to do so. My office is located in the Calabasas Behavioral Health Offices Suite. There is metered street parking.

These forms, policies, practices and questionnaires are meant to be for your information and to answer potential questions. However, I always welcome the opportunity to answer your questions in person or over the phone and to discuss any concerns you may have now or in the future.

I am looking forward to working together, collaboratively!

Dr. Gia Marson

Gia Marson, Ed.D.
Lic No PSY 18764

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New Client Information & Questionnaire

Name_____
If client is a minor, name of parent(s) or guardian(s)_____

Date of Birth_____ Best contact #_____

In an emergency, contact _____Emergency contact # _____

Mailing Address:_____

Street (Apartment #) City State Zip Code

Residence Address (if different from mailing address): _____
Phone Number(s): Home _____ Cell _____ Work _____
May I call you ... at home? Yes No ... on cell? Yes No ... at work? Yes No
If you are a minor, what are your parents' cell phone and work numbers?
_____
_____

Do you plan to text for scheduling? If so, to which number _____
If you are a minor, is this text contact to your cell number? Yes No
If you are a minor, will your parent(s) or legal guardian(s) text me for scheduling? Yes No

Secure Email is usually used for communicating scheduling, payment information and financial statements. If you do not want to be contacted through email, please provide an alternative way to communicate and I will accommodate you. If you do plan to use email, please provide a password to make it more secure for communicating health information.

Scheduling and Financial Information

To whom should I email scheduling and payment information? _____
To what email address? _____
Please provide a password to make this email contact secure: _____
If not through email, how would you prefer to be discuss scheduling & financial arrangements?
_____

Please provide credit card information for the card that can be used for payments if you prefer to not bring payment to each appointment.
Name on card: _____
Billing address for card if different from your address above: _____
_____Card #_____Ex Date_____cvv code_____
Your signature authorizing this card to be used for each appointment unless other payment is made at the time of service_____ Date of signature_____
* Feel free to change this payment type at any time by notifying me in writing with the new information you prefer

Insurance Information

Insurance company_____ subscriber and ID#_____
Phone number for insurance company mental health benefits_____
Address for insurance company_____
_____

Personal Information

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Are you... Single Married/Partnered Separated Divorced Widowed Other _____
Living with your partner? Yes No Number of years? _____

If you are a minor, are your parents married? Yes No Do you live with both parents? Yes No

List any family members you live with, their ages and your relationship to them.

_____

_____

List any family members you do not live with, their ages, your relationship to them and where they reside.

_____

_____

Are you employed? Yes No Employer Name _____

Occupation _____ Years at this position _____

Are you in school? Yes No Name of School _____Type of degree _____

Primary Care Physician Name _____ Primary Care Physician contact #_____

Therapy Information

Type of help you are seeking? (circle)
Individual Therapy/Counseling Family Counseling Couple's Counseling Other _____

1. Primary reason(s) for seeking help at this time? Please be as specific as possible. _____

_____

2. What are your goals for counseling?

_____

_____

3. What have you tried already?

_____

_____

4. Have you ever been suicidal or made a suicide attempt in the past? Yes No If yes, please explain.

_____

_____

5. Have you experienced any significant loss recently? Yes No If yes, when and what were the circumstances?

_____

6. Have you been the victim of a crime or traumatic event? Yes No If yes, when and what were the circumstances?

_____

7. Do you have any serious or chronic medical conditions (including past surgeries)? Yes No If yes, what type(s) and date(s) of major illness or surgery?_____

_____

8. Do you have a history of serious accidents or injuries, head injury, loss of consciousness, or seizures? Yes No
If yes, what type(s) and date(s)?

_____

9. How do you identify your sexual orientation and gender? _____

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10. Who is in your support system?_____

11. What are your strengths?_____

12. What brings you joy or pleasure?_____

14. How do you relax?_____

15. Do you exercise regularly? Yes No Frequency_____ Type_____
16. Do you affiliate with a religious or spiritual group? Yes No Type_____
17. What are your hobbies?_____
18. What culture(s) do you identify with? _____
19. What is your ethnicity?_____
20. What language(s) do you speak? _____ Does your family speak English? Yes No
If no, what language do they speak?_____

21. Most people seek therapy to alleviate problems or symptoms, though some come for support or help through a developmental transition. If you are seeking therapy for specific problems of symptoms please be as specific as possible.
Please list all of the problems or symptoms that you are currently experiencing.

Please list all of the problems or symptoms that you have experienced in the past.

Please add any other comments that are important for me to know at this time.

22. Do any of your family members have current or past serious medical, psychiatric or substance abuse problems? If so, please list and add any comments.

Past or Current Therapy and/or Psychiatric Medication Information
Please list all treatment, past and present (feel free to use the back of the page if more space is needed).
Include: therapy or counseling, psychiatric medications, psychiatric hospital admissions, 12 Step programs, intensive outpatient programs & other treatment.

Type & purpose	Date(s)	Provider	Provider Contact #	Was it Helpful?	Yes	No

Consent For Treatment

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I, _____, authorize and request that Gia Marson Ed.D. provide psychological examinations, treatment, assessments, interventions and/or diagnostic procedures which now or during the course of my (or my child's) care as a patient are advisable. The frequency and type of treatment will be decided between Dr. Marson and me.

I understand that the goals and plans for treatment will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that my child or I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I understand if I communicate through text messaging or unsecured email, these are not recommended by Dr. Marson due to the potential for privacy breaches. Dr. Marson will ask me to establish and use secure email messaging or use telephone contact for professional communication and that all electronic communication may become part of the medical record. If I choose to communicate through secure email, I will provide an email address, contact person and password for both scheduling and billing information to be shared between Dr. Marson and me (or my designee). If I choose not to communicate through secure email, I will provide an alternative method to communicate about my treatment and services, including specifically matters related to scheduling and financial information.

Confidentiality:

All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances: 1) when there is a reasonable suspicion or abuse to a child, dependent or elder adult, 2) when the client or credible third party communicates a serious threat of bodily injury to others 3) when the therapist has a reasonable belief that the client may be a danger to him/herself, others or the property of others, and 4) when disclosure is otherwise required by law (such as any report of involvement in child pornography).

Dr. Marson engages in regular professional consultation. In such cases, clients names and identifying information are not revealed.

Emergency Treatment:

If I have a life threatening emergency, I will call 911 or go directly to the nearest emergency room. Dr. Marson is not able to provide 24 hour availability. She will usually return calls within 24 hours or the next business day. When out of town or otherwise unavailable, Dr. Marson will have a qualified professional cover for her.

Payment:

Payment is due at the end of each session unless other arrangements have been made. I will notify Dr. Marson if any problem arises during the course of therapy regarding my ability to make timely payment. Dr. Marson's usual fee for all professional services is $225.00 per therapy hour. In some instances, she may offer a sliding scale for a limited time. She may periodically adjust her fee for which she will give at least 30 days notice to all clients.

Cancelled/Missed Appointments:

A scheduled appointment means that time is reserved for only me or my child. If an appointment is missed or cancelled with less that 24 business-hours notice, I will be billed according to the appointment fee in the next statement or by charging the card for which I have given authorization as method of payment for appointments. I am aware that insurance companies usually will not cover or reimburse for missed appointment charges.

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Delinquent Accounts:

If my account becomes delinquent (past 30 days) Dr. Marson may assign a late fee or begin collection procedures. Dr. Marson will attempt to contact me directly. However, if my account remains delinquent, she may utilize the services of an outside collection agency, retain an attorney or go to small claims court to take action.

Litigation Charges:

If Dr. Marson is required to attend a deposition, hearing or other legal proceedings in the capacity of my current or past psychologist, I will be billed at $300.00 per hour for her time, including preparation and travel time as well as the time she spends at the legal proceeding. If I am a current or past client, 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 medical record.

Telephone or Consulting Charges:

Telephone calls exceeding 10 minutes will be billed on a pro rata basis, based on the 50-minute session fee. At my request and with my authorization, Dr. Marson may communicate with others on my (or my child's) behalf. If these calls exceed 10 minutes, Dr. Marson may attend sessions or treatment team meetings at other locations on a clients behalf--such as hospitals, residential treatments centers or family meetings-- for which her regular fees will apply. I may be billed on a pro rata basis based on the 50-minute session fee. Insurance companies and managed care organizations will not reimburse for telephone time, unless prior authorized.

Email and Texting:

Dr. Marson strongly recommends phone and secured email for communication. She will rarely respond to text messaging, with the exception of for scheduling purposes, from clients or others on their behalf. Dr. Marson will establish secure email communication which is recommended for scheduling, collaboration and billing purposes. Electronic and other forms of communication usually becomes part of the medical record.

Termination of Therapy Services:

Dr. Marson may terminate therapy at her discretion if 1) she does not believe she can provide effective treatment, 2) she believes my needs are outside of the scope of her training or experience, 3) I desire to terminate or it is mutually agreed upon, 4) I fail to comply with Dr. Marson's treatment recommendations, 5) a conflict of interest develops, 6) I fail to pay her fee on a timely basis or 7) if she or I believe it is in my best interest. If either I or Dr. Marson decide to terminate therapy services, she will recommend at least one closure therapy session.

Address Changes:

I will advise Dr. Marson of any changes in my postal or email address, telephone numbers, place of employment or insurance company coverage.

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Acknowledgment and Agreement for Informed Consent

I have read and fully understand this consent for treatment form.

Client/Parent/Guardian Name | Client/Parent/Guardian Signature | Date

Client Name (if client is a minor) | Client Signature (if client is a minor) | Date

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. Once you have done so, please sign and date below.*

Acknowledgment of Receipt of Notice of Privacy Practices

Client's name: _____ Date of birth: _____

Parent/Guardian's Name (if client is a minor):_____

By signing below, I hereby acknowledge receipt of Dr. Marson's Notice of Privacy Practices.

Client/Parent/Guardian Name | Client/Parent/Guardian Signature | Date