AVEDIAN
counseling center

(818) 990 – 0999

Glendale Location
655 North Central Avenue, 17th Floor
Glendale, California 91203

Sherman Oaks Location
15233 Ventura Boulevard, Suite 1208
Sherman Oaks, California 91403

Woodland Hills Location
20300 Ventura Boulevard, Suite 330
Woodland Hills, CA 91364

Studio City Location
11026 Ventura Boulevard, Suite 12
Studio City, CA 91604

Pasadena Location
1250 East Walnut Street, Unit 110
Pasadena, CA 91106

Please fill out the form to the best of your ability, ensuring all questions marked with an asterisk (*) are answered. If no applicable answer, please write N/A

Please select from the following therapists*:

- ☐ Anita Avedian, MS, LMFT #38403
- ☐ Angelica Churchian, MA. LMFT #125124
- ☐ Silva Depanian, MA, LMFT #121864
- ☐ Emma Ekum, MS, LMFT #111175
- ☐ Bryan Hall, MS, LMFT #88922
- ☐ Chrys Gkotsi, MA, LMFT # 113638
- ☐ Vivian Mejia, MA, APCC

Last name*: _____First name*: _____

Address*: _____

_____

City, State, Zip Code*: _____

Date of Birth*: __/__/____ Age*:_____

Cellular phone: _____ Is it okay to leave a message? Y/N

Work phone:_____ Is it okay to leave a message? Y/N

Email Address*: _____

Assigned (Legal) Gender: _____ Gender Identity:_____

Preferred Pronouns:_____ Sexual Orientation:_____

Racial Identity:_____ Marital Status:_____

Do you have kids? Y/N If so, how many? _____What age(s)?_____

Psychiatrist (if any): _____

Presenting problem, e.g., relationship struggles, anxiety, or depression*:

_____

_____

Date of first symptoms*: _____

Have you been to therapy before? Y/N If so, when was your last visit? _____

Briefly describe living situation*: _____

_____

Employment*: _____

What are the symptoms*: _____

_____

List of your current medication(s)*: _____

Other pertinent drug/alcohol history*: _____

Emergency contact*:_____Phone number*: _____

Referred by*: _____Date of first office visit*: _____

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I have been given a copy of an Informed Consent for Psychotherapy. I have been given the opportunity to have any and all questions answered relevant to my proposed psychotherapy.

I agree to enter into a course of therapy with the selected therapist. I understand that the fee ranges between $150 - $300 per 50 minute session based on the therapist I selected and is payable at the time of service.

I understand that cancellations and re-scheduled sessions will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE.

I grant permission for case consult with other professionals as long as standard care is exercised to protect my privacy and confidentiality. I understand that if I elect to use medical insurance benefits for these services my insurance company will be informed of a medical diagnosis and certain relevant aspects of my treatment, including procedure codes, and other standard pertinent history and prognosis information.

I have been advised regarding the limits of above stated confidentiality and I agree that I will not authorize the execution of a subpoena for any purpose. I hereby authorize my therapist to resist subpoenas executed by any other person or persons in order to protect and insure my privacy and confidentiality.

I have read and understand the information contained in the Client Information Sheet. I have been given the opportunity to have any and all questions answered relevant to my proposed psychotherapy.

Please sign your name below to indicate that the above is true and that you've read and agreed to the informed consent*:

_____

Date*: _____

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INFORMED CONSENT FOR PSYCHOTHERAPY
CLIENT INFORMATION SHEET

General Information

The therapeutic relationship is a mutual endeavor to which the therapist contributes knowledge and skill in psychology and to which the client brings specialized personal knowledge and a commitment to work on his/her own problems. The goals of psychotherapy are both general and specific. General goals include promoting a greater self-awareness of the client's feelings, motivations, behavior and interactions with other persons in his/her life. This awareness and understanding will hopefully promote clarification of personal goals, values and priorities and thus, enable him/her to cope with life tasks in a more directed and fulfilling manner. Specific goals in psychotherapy depend on the unique circumstances of each client.

The techniques utilized in the process of psychotherapy may include the disclosure by the client of deeply personal thoughts, feelings and experiences. The therapist may provide feedback to the client in order to generate insight and provide new coping skills. At times, the therapist may offer confrontation of certain beliefs, attitudes, or behaviors as a device that will allow the client to risk new behaviors beyond his/her present level of function.

Research supports the overall effectiveness of psychotherapy, but it is also clear that psychotherapy is not effective in all cases. Many factors seem to influence the effectiveness of psychotherapy, and I will continually monitor your progress and make adjustments as necessary. You can improve the effectiveness of your therapy by attending sessions regularly. It is also possible that changes brought about by your psychotherapy will be experienced by you or your family members as undesirable or uncomfortable- sometimes because change is uncomfortable in and of itself and sometimes because changes can upset a given family equilibrium. Any concerns in this regard should be discussed with me.

Initials: * _____

Confidentiality

The session content and all relevant materials to the client's treatment will be strictly held confidential unless the client requests in writing to have all or portions of such content released

to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

8. If a client involves a therapist in a conspiracy to commit a crime or a conspiracy to avoid detection from prosecution.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate to not to engage in any lengthy discussions in public or outside of the therapy office.

Billing

The fee with Anita Avedian, LMFT, is **$300** per 50-minute session. The fee for Emma Ekum, LMFT, is **$250** per 50-minute session. The fee for Chrys Gkotsi, LMFT, Silva Depanian, LMFT, Angelica Churchian, LMFT, and Bryan Hall, LMFT, is **$200** per 50-minute session. The fee for working with an Associate Professional Counselor therapist is **$150** per 50-minute session. Please note that we currently don't have any Associates at our Center. All fees are payable at the time of service unless other arrangements are agreed upon in advance. A detailed invoice of charges can be obtained for the purpose of submitting to an insurance carrier or other third party payer for reimbursement. There will be no fee for this service on current bills however an

outstanding account may be charged a $5.00 service fee for each statement. Past due accounts may be additionally subjected to interest charges of 5% per month if a balance is neglected for more than 30 days. In the case of a third party payer, the client is fully responsible for all charges not covered by insurance. If the balance is past due 90 days, it is subject to go to collections.

Conversations in between sessions (before or after your scheduled time), not related to scheduling or rescheduling, do incur a cost per minute. Please ask your counselor if you're unsure about the per minute rate policy or what qualifies this cost.

A $20.00 service charge will be charged for any checks returned for any reason for special handling. Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

Credit card payments can be made through IVY Labs app. This is a HIPAA compliant system that allows for you to update your credit card information into the app, and it will allow the therapist, to charge your card on file following each session, and following sessions missed or cancelled less than 24 hours of the scheduled appointment.

Fee Schedule

Time-Frame Fee for Anita Avedian, LMFT.

50 - minute session $300

75 - minute session $450

90 - minute session $540

For clients who wish to maintain their privacy, or who are unable to travel to the office, Anita offers house visits at her sole discretion. Home visits are reserved for sessions lasting 90-minutes or longer.

Time-Frame	**Fee**
90 - minute session	$750 (within a 10-mile radius)

Time-Frame Fee for Emma Ekum, LMFT

50 - minute session $250

75 - minute session $375

90 - minute session $450

Time-Frame Fee for Chrys Gkotsi, LMFT, Silva Depanian, LMFT, Angelica Churchian, LMFT, and Bryan Hall, LMFT.

50 - minute session $200

75 - minute session $300

90 - minute session $360

Time-Frame Fee for an Associate Professional Counselor

50 - minute session $150

75 - minute session $225

90 - minute session $270

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours. The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

Good Faith Estimate

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost.
Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.
You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.
You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.
If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Initials:* _____

Clinical Supervision of Associates

When working with one of our team's Associate Professional Counselor, the Clinical Supervisor monitors the Associate's work through weekly supervision of cases, progress notes, and/or occasional audio/ video recording of sessions. The clinical supervisor may sit in on a session to better understand a case. I (the client) will receive advanced notice when audio/video recordings, and sit ins are planned, and I will always have the final say as to whether or not I agree to be observed. All viewers of the audio/visual recorded file(s), including myself, are bound by the ethical standards of the American Psychological Association. The file(s) will be treated with confidentiality by being stored on a password protected computer and will be destroyed as soon as the Associates receive their licensure and are no longer in need of supervision hours. By signing below, I am stating that I have read and understood the informed consent audio/video recording and that I am permitting Avedian Counseling Center to audio/video record or attend our session (s) and review the audio/video file(s) with the aforementioned individuals for supervision purposes.

Initials: * _____

Litigation Limitation:

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Initials: * _____

Availability

Therapists will be available via voicemail during standard business hours. Any more than one phone call that goes beyond 15 minutes in any one-week period will result in you being charged on a quarter of an hour basis. This is based on your regular therapy session rate. If your therapist is on vacation or it is after business hours, and you are having an emergency, dial 911 or The Suicide Prevention Hotline (877) 727-4747, unless you have arranged for a back-up therapist to be available while your therapist is on vacation.

Initials: * _____

Social Media Policy

Friending- Please do not send requests through any social media sites, including Facebook, LinkedIn, and Twitter. Therapists don't accept friend or contact requests from clients, including former clients since it can compromise your confidentiality.

Fanning- You are welcome to view our Facebook Pages, however we do not encourage you to fan or like our pages since it could compromise client confidentiality.

Following- We don't encourage you to follow us on Twitter. In the case that you do, please note that we cannot follow you in return.

Should you have any questions regarding our social media policy, please ask your therapist, and they will clarify.

Initials: * _____

Termination

Our relationship is strictly voluntary and you may leave the psychotherapy relationship anytime you wish. However, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Your therapist may terminate treatment after appropriate discussion with you and a termination process if they determine that the psychotherapy is not being effectively used or if you are in default on payment. They will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, they will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Initials: * _____

Credit Card on File

Payments are due at the time of service. Your therapist requires a credit or debit card on file in order to schedule sessions. The credit card on file can be used to pay for copays, co-insurance, deductibles, no shows/late cancellations, or out of pocket payments if another payment method is not used at the time of the session. If a late cancellation or no show is incurred, the credit card on file will be charged our full fee on the day of scheduled session. Clients may also pay by cash or check at each session. Your credit card information will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Initials: * _____

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with my therapist.

I understand I have the following rights under this agreement:

- I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential, outside of the mandatory reporting laws stated within my registration form.

- I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

- I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

- I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. I understand that my therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. In such circumstances, telephone sessions can be used.

- In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

- One of the advantages to Telehealth is that it can flexibly provide continuity of care when an in-person treatment session cannot be conducted in the office. Similar to a regular in-person therapy session, telehealth allows for both verbal and non-verbal communication.

- Similar to in-person services, if an emergency should occur during a telehealth session, the psychotherapist may consider taking any steps necessary to ensure the safety of the patient or of others.

- Telehealth is governed by all the same ethics and laws that cover in-office, in-person, face-to-face psychological service. So, all other policies and consents in the psychotherapist's office agreement forms apply to telehealth services. This document is an addendum to, and does not substitute for, Avedian Counseling Center's standard in-office services agreements.

- Telehealth services are a professional service, and a fee is charged at the same rate as in-person services.

- Even when health insurance covers in-person services, health insurance may limit or deny coverage of telehealth services. I, as the client, am responsible to confirm and know in advance what my insurance may or may not cover. If my insurance does not cover telehealth services, I understand that I will not receive the reimbursement.

- Telehealth sessions are scheduled in advance by prior arrangement. Scheduling a telehealth appointment involves reserving time specifically for you.

- Cancellations and missed appointments are treated similar to in-person policies.

- I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event, or condition on which this content expires. I have the right to opt in or opt out of the methods of telehealth communication at any time, without affecting my right to future care or treatment.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I hereby authorize Avedian Counseling Center to use HIPAA compliant and secure telemedicine technology for our therapy sessions.

I understand that I can withdraw my consent to Telehealth communications by providing written notification at any time. My signature below indicates that I have read this Agreement and agree to its terms.

Please select one: *

- ☐ I do agree to telehealth sessions
- ☐ I do NOT agree to telehealth sessions

If you do authorize telehealth sessions, please sign here:

Notice of Privacy Practices

1. **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.**

2. **I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

1. **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

2. **For Treatment.** I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

3. **To Obtain Payment for Treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might

send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

4. **For Health Care Operations.** I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

5. **Patient Incapacitation or Emergency**. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

6. **Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

    1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

    2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

    3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

    4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

    5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

    6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of

others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to Family, Friends, or Others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. **The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

2. **The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is

reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

3. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

2003. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

1. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your

PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

2. **The Right to Receive a Paper Copy of this Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via email.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

1. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Anita Avedian, LMFT
15233 Ventura Blvd., Suite 1208
Sherman Oaks, CA 91403
(818) 426-2495

VII. EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on April 14, 2003

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Please sign your name below to indicate that you've read and agreed to the HIPAA policies: *

_____

Print your full name: * _____