# (818) 383-1399

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**Glendale Location:** 320 Arden Avenue, Suite 240, Glendale, CA 91203

**Sherman Oaks Location:** 15233 Ventura Boulevard, Suite 1208, Sherman Oaks, CA 91403

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

**Pasadena Location:** 101 East Green Street, Suite 4, Pasadena, CA 91105

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

# Please complete the form to the best of your ability. 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
* Alexandra Mirsakova, AMFT #132394
* Garo Demirjian, AMFT #137503

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, depression):

Date of first symptoms: \_\_\_\_\_

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

What are the symptoms:

List of your current medication(s):

Briefly describe living situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 - $350 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 consultation 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:*

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 their struggles. 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 others in their life. This awareness and understanding will hopefully promote clarification of personal goals, values and priorities and thus, enable them 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 their 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 counselors 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 your counselor.

# 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, your therapist 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 you run into your therapist outside of the therapy office, your therapist will not acknowledge for confidentiality purposes. Your right to privacy and confidentiality is of the utmost importance to the Avedian Counseling Center, and as such, our therapists will not jeopardize your privacy. However, if you acknowledge your counselor first, your counselor can acknowledge you in return. Even so, your counselor will not engage in lengthy discussions in public or outside of the therapy office.

# Billing

The fee with Anita Avedian, LMFT, is **$350** per 50-minute session. The fee to work with one of our Licensed Marriage and Family Therapists is **$250** per 50-minute session. The fee to work with an Associate Marriage and Family Therapist or Associate Clinical Social Worker is **$150** per 50-minute session.

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, the account is subject 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 fee will be charged for any disputed charges. Cancellations and re-scheduled sessions 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 canceled less than 24 hours of the scheduled appointment.

Fee Schedule

# Fees based on length of session working with Anita Avedian, LMFT.

# 50 - minute session $350

# 75 - minute session $525

# 90 - minute session $630

For clients who wish to maintain their privacy, or who are unable to travel to the office, some of the ACC counselors offer house visits at their sole discretion. Home visits are reserved for a minimum of a 90- minute session.

# Time-Frame Fee

90 - minute session $850 (within a 10-mile radius)

# Fees based on length of session working with a Licensed Marriage and Family Therapist.

50 - minute session $250

75 - minute session $375

90 - minute session $450

# Fees based on length of session working with an Associate Marriage and Family Therapist, or Associate Clinical Social Worker

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 a cancellation is made within 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 need 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, healthcare 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 healthcare 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.](http://www.cms.gov/nosurprises)

**Initials:**

**Clinical Supervision of Associates**

When I (the client) am working with one of the ACC team's Associate Marriage and Family Therapists, Associate Clinical Social Workers or Associate Professional Clinical Counselors, I understand that 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/video 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 for audio/video recording and that I am permitting the 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 10 minutes in any one-week period will result in you being charged the per-minute fee which 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 Instagram or 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 the full fee. You 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. Therefore, I understand that 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, I understand the psychotherapist may consider taking any steps necessary to ensure the safety of the client (myself) or of others.
* Telehealth is governed by all the same ethics and laws that cover in-office, in-person, face-to-face psychological service. As such, I understand all other policies and consents in the psychotherapist’s office agreement forms apply to telehealth services. This document is an addendum to, and not a substitute for, Avedian Counseling Center’s standard in- office services agreements.
* I understand that 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 for confirming and knowing 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.
* I further understand that telehealth sessions are scheduled in advance by prior arrangement. Scheduling a telehealth appointment involves reserving time specifically for myself, the client.
* I understand that cancellations and missed appointments are the same as the previously mentioned policies for in-person sessions.
* 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 below:

**NOTICE OF PRIVACY PRACTICES**

**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.**

I am required by law to maintain the privacy and security of your protected health information (“PHI”) and to provide you with this Notice of Privacy Practices (“Notice”). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization (“Authorization”). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

**Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent.** I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment.** I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. **To obtain payment for your 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 to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. **For health care operations.** I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

**Certain Uses and Disclosures Require Your Authorization.**

1. **Psychotherapy Notes.** I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law, and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. **Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

**Certain Uses and Disclosures Do Not Require Your Authorization**. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10.Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

**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.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. **The Right to See and Get Copies of Your PHI.** Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you.

I will provide you with a copy of your record, or a summary of it, if you agree

to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

**5. The Right to Get a List of the Disclosures I Have Made.**

You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable fee for each additional request.

6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

**HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you think I may have violated your privacy rights, you may file a complaint with the Executive Director of Avedian Counseling Center, as the Privacy Officer for our practice. The contact information is as follows:

Anita Avedian, LMFT

15233 Ventura Blvd., Suite 1208

Sherman Oaks, CA 91403

(818) 426-2495

anita@anitaavedian.com

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;

2. Calling 1-877-696-6775; or,

3. Visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 20, 2013.