



# AVEDIAN

counseling center

**(818) 383-1399**

**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:** 1250 East Walnut Street, Suite 110, Pasadena, CA 91106

**Larchmont Location:** 321 N Larchmont Blvd, Suite 506, Los Angeles, CA, 90004

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
- Chrys Gkotsi, MA, LMFT # 113638
- Nicholas Schaub, MS, AMFT # 159459
- Raha Shahbazian, MA, AMFT# 489659
- Rita Akhian, AMFT #142256
- Sasha Kleinman, AMFT #148870
- Silva Depanian, MA, LMFT #121864
- Thea Brown, AMFT #138429
- (Therapist name if not listed above) \_\_\_\_\_

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): \_\_\_\_\_



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Presenting problem (e.g., relationship struggles, anxiety, depression):

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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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## **Agreement and Consent**

I understand that I have access to my Informed Consent for Psychotherapy and additional completed forms via my Ensora client portal. My counselor is available to answer any questions relevant to my proposed psychotherapy services.

I agree to enter into a course of therapy with the selected therapist. I understand that the fee ranges between \$200 - \$400 per 50-minute session, based on the therapist I select, and is payable at the time of service.

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

I grant permission for case consultations with other professionals, provided that standard care is exercised to protect my privacy and confidentiality. I understand that if I elect to use my medical insurance benefits for these services, my insurance company will be informed of my 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 the above-stated confidentiality, and I agree not to authorize the execution of a subpoena for any purpose. I hereby authorize my therapist to resist subpoenas executed by any other person or persons to protect and ensure 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: \_\_\_\_\_



**INFORMED CONSENT FOR PSYCHOTHERAPY  
CLIENT INFORMATION SHEET**

**General Information**

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

The techniques used in psychotherapy may include the client disclosing personal thoughts, feelings, and experiences. The therapist may provide feedback to the client to generate insight and provide new coping skills. At times, the therapist may offer confrontation of certain beliefs, attitudes, or behaviors as a means to enable the client to engage in new behaviors beyond the client's present level of functioning.

Research supports the overall effectiveness of psychotherapy, but it is also clear that psychotherapy is not effective in all cases. Many factors influence the effectiveness of psychotherapy, and your counselor 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 may be experienced by you or your family members as undesirable or uncomfortable at times, due to discomfort with change, or that these changes can upset a given family equilibrium. Any concerns in this regard should be discussed with your therapist.

**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



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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, the counselor may need to consult with other professionals in their areas of expertise to provide the best treatment for you. In this context, your information may be shared without using your name.

If you encounter the counselor outside the therapy office, please note that the counselor will not acknowledge you first. Your right to privacy and confidentiality is essential; the counselor will not compromise it.

**Initials:** \_\_\_\_\_

## **Fees**

The fee with the Executive Director is \$400 per 50-minute session. The fee for a 50-minute session with a Licensed Marriage & Family Therapist is \$300. The fee with an Associate Marriage and Family Therapist is \$200 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 submission 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 incur additional interest charges of 5% per month if the balance is not paid within 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 remains past due for 90 days, it may be referred to collections.

Conversations between sessions (before or after your scheduled time), unrelated to scheduling or rescheduling, will incur a cost-per-minute rate. Please ask your counselor if you're unsure about the per-minute rate policy or what qualifies for this cost. Any request for reports must be discussed and agreed upon with the counselor at the start of your treatment. All reports will incur a per-minute rate, including the file review, preparation, and submission of a report. Note that fees for subpoenaed attendance will be four (4) times the regular session fees charged in addition to travel



time.

A \$20.00 service charge will be charged for any checks returned for any reason for special handling. Cancellations and rescheduled 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. Please note that all sessions will end on time ,despite arriving late to your scheduled session.

Credit card payments can be made through the IVY Labs app. The app is a HIPAA-compliant system that allows you to update your credit card information in the app. Your card on file will be charged at the time of service, including missed or sessions not canceled within 24 hours of your scheduled appointment.

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### Fee Schedule

#### **Time-Frame Fee for the Executive Director.**

50 - minute session \$400

75 - minute session \$600

90 - minute session \$720

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#### **Time-Frame Fee for a Licensed Marriage and Family Therapist**

50 - minute session \$300

75 - minute session \$450

90 - minute session \$540

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#### **Time-Frame Fee for an Associate Marriage and Family Therapist**

50 - minute session \$200

75 - minute session \$300

90 - minute session \$360

Please remember to cancel or reschedule 24 hours in advance. If you cancel less than 24 hours in advance, you will be responsible for the entire fee. The standard meeting time for psychotherapy is 50 minutes. However, you are responsible for determining the length of your sessions. If you need to



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adjust the 50-minute session, you must discuss it with the therapist.

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## **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).

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## **Clinical Supervision of Associates**

When working with one of our team's Associate Marriage and Family Therapists and/or Associate Professional Counselors, 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 observe a session to improve clinical care for the client. 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 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 are destroyed as soon as the Associates receive their licensure and no longer need supervised 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.

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## **Litigation Limitations and Fees:**



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Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure about many matters that 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 disclosure of the psychotherapy records be requested unless otherwise agreed upon. Any request for reports must be discussed and agreed upon in advance with the counselor at the start of your treatment. Please note that fees for written reports apply.

Clients are discouraged from having their counselor or records subpoenaed for litigation. Even though the client is responsible for the testimony fee, this does not mean the testimony will be in the client's favor. Testifying is only based on facts and the counselor's professional opinion. It's crucial not to damage the trust you build with your therapist.

Although we do not provide custody evaluations or expert witness testimony, in the case your therapist does receive a subpoena, a one-week notice of any requested court appearance is required to provide the necessary time to reschedule clients. Please note that there will be an additional \$300 express charge if there is less than a 1-week notice for appearance in the courtroom.

Fees related to court action are as follows:

1. Preparation Time (including submission of records): \$350/hour (billable in 30-minute increments)
2. Phone calls/ virtual meetings: \$250/hour (billable in 15-minute increments)
3. Depositions and/or giving testimonies: \$500/hour for the specific hour required. If the general day is required, a fee of \$2000 will be charged. A "general day" can include the therapist being physically present at court for the day, as well as the therapist being asked to remain on standby for the day, even if the appearance is virtual. Any travel time required will accrue a fee of \$250/hour.
4. All attorney fees and costs that are incurred by the company as a result of the legal action are the client's responsibility. This includes consultation and conversations with attorneys, psychiatrists, and other professionals as it pertains to the case.
5. The minimum charge for any physical court appearance, not including transit time, is \$2000

A retainer of \$2000 is due at least 72 business hours before the scheduled court appearance, and we do NOT work on a contingency basis. If your counselor is subpoenaed, and the case is continued with less than 48 business hours' notice before the beginning of the day of the scheduled court appearance and/or testimony, then you will incur an additional charge of \$2500, which must be paid 24 hours before the required appearance. All fees listed above are doubled if the therapist is scheduled to be on leave or out of town, and must therefore return from or cancel their leave to accommodate the subpoena. Alternatively, the counselor may accommodate a request for a virtual appearance for the regular hourly or daily fee.

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### **Therapist Availability and Emergency Contact Policy**

Therapists will be available via voicemail during standard business hours. Phone calls outside of a scheduling discussion will result in a charge based on the per-minute rate, which is based on your therapy session rate. If your therapist is on vacation or it is after business hours, and you have an emergency, dial 911 or the Suicide Prevention Hotline 988 unless you have arranged for a backup therapist to be available while your therapist is on vacation.

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### **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.

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### **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 used effectively 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.

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### **Payment Protocol**

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.

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### **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 I must give my written consent to disseminate any personally identifiable images or information from the Telehealth interaction to other entities.
- I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders and personal and relational issues, there is no guarantee that all treatments 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.
- I also understand that Telehealth treatment differs from in-person therapy and that if my therapist believes I would be better served by other psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area who can provide such services.
- Telehealth has the advantage of flexible 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 verbal and nonverbal communication.
- Similar to in-person services, if an emergency occurs during a telehealth session, the psychotherapist may consider taking any necessary steps to ensure the patient's or others' safety.



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- Telehealth is governed by all the same ethics and laws that cover in-office, in-person, and face-to-face psychological services. So, all other policies and consent forms in the psychotherapist's office agreement 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 professional services, and a fee is charged at the same rate as in-person services.
- Even when health insurance covers in-person services, it may limit or deny coverage of telehealth services. As the client, I am responsible for confirming and knowing what my insurance may or may not cover. If my insurance does not cover telehealth services, I understand that I will not receive 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 similarly to in-person policies.

I understand that I may revoke this authorization by giving 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 telehealth communication methods 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. My agreement to use telehealth services will allow me to have hybrid (in-person/telehealth) sessions with my therapist.

I agree to have Telehealth as an option to my therapy services. I understand that I can request an in-person session at any time:

If you do consent to telehealth sessions, please enter your name below:

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## 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.**

**Your counselor has a legal duty to safeguard your protected health information (PHI).**

Your counselor is legally required to protect the privacy of your Protected Health Information (PHI). This includes information that can be used to identify you and pertains to your past, present, or future health or condition, the provision of health care, or the payment for such health care. Your counselor must provide you with this Notice, which explains the privacy practices in place and how, when, and why your PHI will be “used” or “disclosed.” A “use” of PHI occurs when your counselor shares, examines, utilizes, applies, or analyzes such information within the practice; PHI is “disclosed” when it is released, transferred, or divulged to a third party outside the practice. With certain exceptions, your counselor 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. Additionally, your counselor is legally obligated to adhere to the privacy practices described in this Notice.

However, your counselor reserves the right to change the terms of this Notice and the privacy policies at any time. Any changes to the policies will apply to all PHI on file. Before implementing any changes, your counselor will promptly update this Notice and post a new copy in the office. You may also request a copy of this Notice or view a copy at the office.

### HOW YOUR PHI MAY BE USED AND DISCLOSED

Your counselor may use and disclose your PHI for various reasons. For some uses and disclosures, prior written authorization is required; for others, it is not. Below are the different categories of uses and disclosures, along with examples.

1. Uses and disclosures relating to treatment, payment, or healthcare operations that do not require prior written consent are listed below. Your counselor may use and disclose your PHI without your consent in the following scenarios:

a. For Treatment: Your counselor may use your PHI within the practice to provide mental health treatment, including sharing it with trainees and associates. Your counselor may also disclose your PHI to other licensed healthcare providers involved in your care, such as physicians, psychiatrists, or psychologists. For example, if a psychiatrist treats you, your counselor may share your PHI with them to coordinate care.

b. To Obtain Payment for Treatment: Your PHI may be used and disclosed to bill and collect payment for services provided. For instance, your counselor may send your PHI to your insurance company or health plan to get paid for the services. Your PHI may also be shared with company business associates, such as billing companies, claims processing companies, and others that process the Center's health care claims.



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c. For Healthcare Operations: Your PHI may be used to operate the practice. For example, your counselor might use it to evaluate the quality of care or the performance of healthcare professionals. PHI may also be disclosed to accountants, attorneys, or consultants for healthcare operations.

d. Patient Incapacitation or Emergency: If you are incapacitated or have an emergency, your counselor may disclose your PHI without your consent. For instance, emergency treatment may be provided while attempts are made to obtain your consent later.

2. Certain other uses and disclosures that do not require consent or authorization are listed below. Your counselor may use or disclose your PHI in the following circumstances:

a. When required by federal, state, or local laws (e.g., reporting abuse or neglect). For example, your counselor may have to disclose information about victims of abuse or neglect to applicable governmental officials when a law requires your counselor to report it to government agencies and law enforcement personnel.

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

c. For law enforcement purposes (e.g., responding to a search warrant, reporting crimes occurring on the premises).

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

e. 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 (e.g., reporting adverse reactions to medications).

f. For health oversight activities (e.g., your counselor may have to provide information to assist the government in conducting an investigation or inspection of a healthcare provider or organization).

g. To avert serious threats to health or safety (e.g., your counselor 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 who can prevent the threatened harm from occurring.)

h. For specialized government functions (e.g., if you are in the military, your counselor may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations).

I. To remind you about appointments and inform you of health-related benefits or services. For



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example, your counselor may use or disclose your PHI to remind you about your appointments or to inform you about treatment alternatives, other healthcare services, or other healthcare benefits that are offered or of interest to you.

3. Certain uses and disclosures require you to have the opportunity to object. Unless you object, your counselor may disclose PHI to family, friends, or others involved in your care. For emergencies, this opportunity to object may be obtained retroactively.

4. Disclosures to family, friends, or others. Your counselor may provide your PHI to a family member, friend, or other person you indicate is involved in your care or the payment for your health care unless you object to it in whole or in part. The opportunity to consent may be obtained retroactively in emergencies.

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

6. Psychotherapy Notes. I do not keep “psychotherapy notes” as that term is defined in 45 CFR§ 164.501. I maintain a record of your treatment, and you may request a copy of such record at any time or request that I prepare a summary of your treatment. There may be reasonable, cost-based fees for copying the record or preparing a summary.

## YOU HAVE THE FOLLOWING RIGHTS CONCERNING YOUR PHI:

### A. The Right to Request Limits on Uses and Disclosures

Individuals have the right to request restrictions or limitations on their counselor's uses or disclosures of PHI to carry out treatment, payment, or healthcare operations. They also have the right to request that their counselor restrict or limit disclosures of PHI to family members, friends, or others involved in their care or who are financially responsible for their care. Such requests must be submitted in writing to the counselor. The counselor will consider these requests but is not legally required to accept them. If a request is accepted, the counselor will document the agreement in writing and abide by it, except in emergencies. However, individuals cannot limit the uses and disclosures that are legally required.

### B. The Right to Choose How PHI Is Sent

Individuals have the right to request that their counselor send confidential information to an alternate address (e.g., a work address rather than a home address) or by alternate means (e.g., email instead of regular mail). The counselor must agree to such requests as long as they are reasonable, the individual specifies how or where they wish to be contacted, and, when appropriate, provides information on how payment for such alternate communications will be handled. The counselor may not require an explanation of the request as a condition for providing confidential communications.



### C. The Right to Inspect and Receive a Copy of PHI

In most cases, individuals have the right to inspect and receive a copy of their PHI maintained by the counselor. A written request must be submitted to access this information. If the counselor does not have the requested PHI but knows who does, they will inform the individual how to obtain it. The counselor will respond to the request within 30 days of receiving it. In certain situations, the counselor may deny the request. If denied, the counselor will provide a written explanation of the reasons for the denial and instructions on how to have the denial reviewed.

If copies of PHI are requested, the counselor may charge their per-minute rate to prepare the copy. If the individual agrees to the summary and associated costs in advance, the counselor may offer a summary or explanation of the PHI instead of providing the requested PHI.

### D. The Right to Receive a List of Disclosures Made

Individuals have the right to receive a list, known as an Accounting of Disclosures, of instances in which the counselor has disclosed their PHI. The list will not include disclosures made for treatment, payment, or health care operations; disclosures made to the individual; disclosures authorized by the individual; 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 January 1, 2025.

The request for an Accounting of Disclosures will be responded to within 60 days of receiving such a request. The provided list will include disclosures made in the last six years unless a shorter time is requested. The list will consist of 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. The list will be provided at no charge; however, if more than one request is made in the same year, a reasonable, cost-based fee may be charged for each additional request.

### E. The Right to Amend PHI

If an individual believes that there is a mistake in their PHI or that a piece of important information is missing, they have the right to request a correction to the existing information or the addition of the missing information. The request, along with the reason for the request, must be provided in writing. A response will be given within 60 days of receiving the request to correct or update the PHI. The request may be denied in writing if the PHI is (i) correct and complete, (ii) not created by the entity handling the request, (iii) not allowed to be disclosed, or (iv) not part of the entity's records. A written denial will state the reasons for the refusal and explain the individual's right to file a written statement of disagreement with the denial. If no statement is filed, the individual has the right to request that their original request and the denial be attached to all future disclosures of their PHI. If the request is approved, the necessary changes will be made to the PHI, and the individual and any other relevant parties will be informed of the update.



#### F. The Right to Receive a Paper Copy of This Notice

Individuals have the right to receive a paper copy of this notice, even if they agree to receive it electronically.

#### HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If individuals believe their privacy rights have been violated or disagree with a decision about their PHI, they may file a complaint with the counselor listed in Section VI below. Complaints may also be sent in writing to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. The counselor will not retaliate against anyone for filing a complaint.

#### PERSON TO CONTACT FOR INFORMATION OR COMPLAINTS

For questions about this notice or complaints about privacy practices, individuals may contact:

Anita Avedian, LMFT  
15233 Ventura Blvd., Suite 1208  
Sherman Oaks, CA 91403  
(818) 383-1399

VII. EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on January 1, 2025

#### **Acknowledgments of Receipt of Notice of Privacy Practices**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that has been given to you.

Please type your full name below to indicate that you've read and acknowledged receipt of the Notice of Privacy Practices:

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_