

# Anita Avedian, M.S., LMFT

Glendale • Hollywood • Sherman Oaks • Woodland Hills

California License # LMFT 38403  
(818) 426-2495

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## Client Registration for Couples

Name: _____	DOB: _____	Age: _____
Address: _____		
Home Phone: _____	Is it okay to leave a message? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Work Phone: _____	Is it okay to leave a message? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Email Address: _____		
Employment: _____		
Current medications: _____		
Other pertinent drug/alcohol history: _____		
Person to Contact in Emergency: _____		Phone: (____) _____

Name: _____	DOB: _____	Age: _____
Address: _____		
Home Phone: _____	Is it okay to leave a message? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Work Phone: _____	Is it okay to leave a message? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Email Address: _____		
Employment: _____		
Current medications: _____		
Other pertinent drug/alcohol history: _____		
Person to Contact in Emergency: _____		Phone: (____) _____

Referred by: \_\_\_\_\_

Date of first office visit: \_\_\_\_\_

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

We agree to enter into a course of therapy with Anita Avedian, MFT as of \_\_\_\_\_.

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

We grant permission for case consult with other professionals as long as standard care is exercised to protect our privacy and confidentiality. We understand that if we elect to use medical insurance benefits for these services our 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.

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

By signing below, we agree to all the terms of the Informed Consent for Psychotherapy:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
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 \_\_\_\_\_ Initials \_\_\_\_\_

Billing

My standard fee is **\$250** per 50-minute session, unless otherwise agreed upon. 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 1% per month if a balance is neglected for more than 90 days. In the case of a third party payer, the client is fully responsible for all charges not covered by insurance.

If payment is through a credit card, I could pay through PayPal, or pay through Ivy Labs which is a HIPAA compliant credit card service. The credit card gets stored, and will be charged following every session, or missed session.

Initials \_\_\_\_\_ Initials \_\_\_\_\_

Fee Schedule

Time-Frame	Fee
50- minute session	\$ 250
75- minute session	\$ 375
100 - minute session	\$ 450

Saturday and Sunday appointments can be made available at \$6/minute rate: \$300 for a 50-minute session.

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.

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.

Initials \_\_\_\_\_ 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.

Initials \_\_\_\_\_ Initials \_\_\_\_\_

## Availability

I 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 I am 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 we have arranged for a back-up therapist to be available while I'm on vacation.

Initials \_\_\_\_\_ Initials \_\_\_\_\_

## Social Media Policy

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

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

*Following-* I don't encourage you to follow me on Twitter. In the case that you do, please note that I cannot follow you in return.

Should you have any questions regarding my social media policy, please ask me, and I will clarify.

Initials \_\_\_\_\_ 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. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I 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, I 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 \_\_\_\_\_ Initials \_\_\_\_\_

## About the therapist

As a consumer of mental health services you have a right to know about the qualifications of your therapist. I have a Master's degree in Educational Psychology with an emphasis in Marriage, Family, and Child Counseling. I have extensive experience facilitating cognitive-behavior interventions to people who have high levels of anxiety and/or severe depression. Another treatment modality I use in my practice is Thought Field Therapy (TFT). TFT is a unique technique that is very effective for people who have experienced trauma, anxiety, or panic attacks. Several other certifications I have include Anger Management, Substance Abuse Treatment, and Critical Incident Stress Management.

Initials \_\_\_\_\_ Initials \_\_\_\_\_