

Briana Kilian, MA, MFTI
Marriage and Family Therapy Registered Intern, IMF 81364

Under the Supervision of Abigail Burd, LCSW, LCS26867

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Briana Kilian's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my therapist. If after discussing my concerns, I feel my therapist has not settled my issue with privacy, I may speak with her supervisor Abigail Burd, LCSW, at Abby@AbigailBurdLCSW.com. If I still have concerns, I may contact the California Board of Behavioral Sciences at http://www.bbs.ca.gov/consumer/complaint_info.shtml, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

Signature of Patient/Client

Date

Signature or Parent, Guardian or Personal Representative

Date

* If you are signing for an individual, please describe your legal authority to act for this individual (parent, power of attorney, healthcare surrogate, etc.).