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GMH NEUROFEEDBACK CLINIC
CONSENT + AGREEMENT

INFORMED CONSENT FOR NEUROFEEDBACK TRAINING

I authorize Grew, Morter & Hartye, P.A. ("GMH") to provide me, or _____, of whom I am the legal parent/guardian or personal representative, with EEG biofeedback (neurofeedback) assessment, evaluation, and therapy (collectively "neurofeedback therapy").

I understand that neurofeedback therapy is a treatment based upon the provision of information regarding the activity of the brain in such a manner that the brain can comprehend the information as the activity is going on. I understand that the brain, mind and body make use of this information to produce changes. These changes in brain-body-mind states are often represented in overt behavioral changes and I am aware that I may also need to learn new patterns of behavior to produce the kinds of changes that I am seeking to achieve through the neurofeedback therapy.

I understand that neurofeedback therapy requires placement of surface electrodes on my scalp for the purpose of recording my EEG, and the use of this signal is to provide video displays and audio signals. Further, I understand that neurofeedback therapy is non-invasive.

I understand that certain individuals have reported that neurofeedback therapy may affect my body's response to medications for my condition, as well as for unrelated conditions. I understand that I should not stop or alter any of my medications without consulting my physician and psychiatrist. I should continue other, ongoing therapies, including but not limited to neurofeedback therapy, until otherwise advised by the physician. Should new symptoms develop, it is my responsibility to inform my health care providers, including my neurofeedback practitioner and GMH.

I understand that it is my responsibility, along with the neurofeedback practitioner's responsibility, to monitor and report the subjective effects of neurofeedback therapy. Neurofeedback therapy is based on the input from me. It is very important that I provide my feedback about the effects of the training. During the initial evaluation, I need to disclose accurately all information requested by GMH and/or my neurofeedback practitioner with GMH. Research literature indicates that there are some individuals who are unaffected by neurofeedback therapy. GMH and my neurofeedback practitioner make no representation that I, or any individual client, will improve from neurofeedback therapy.

I understand that neurofeedback therapy is a clinically viable and effective treatment approach whose scientific basis is still being researched. I understand that there are medical professionals who may not endorse the effectiveness of neurofeedback therapy. I agree to submit any dispute with GMH staff members to binding arbitration under the rules of the American Arbitration Association.

FINANCIAL RESPONSIBILITY + AGREEMENT – NEUROFEEDBACK THERAPY

The fee for a neurofeedback therapy session is **$90.00.** I agree to pay the neurofeedback therapy session fee, and acknowledge that payment is due at the time services are rendered. Payment of fees for other services outside of neurofeedback therapy session will be agreed upon prior to the provision of those services.

CANCELLATION POLICY

I understand and acknowledge that **twenty-four (24)** hours advance notice is required to cancel an appointment for neurofeedback therapy. I, as the patient, or the parent/guardian or responsible party of the patient, am fully responsible for payment of the **$90.00** if an appointment for neurofeedback therapy is missed, or if an appointment for neurofeedback therapy is not cancelled at least twenty-four (24) hours prior to the appointment's scheduled time.

I agree to the terms of this GMH Neurofeedback Clinic Consent + Agreement, and I further agree to be responsible for any charges incurred as a result of the enforcement of this Agreement for neurofeedback therapy by GMH staff, for me, or for the patient if I am the patient's parent/guardian or responsible party.

CONSENT FOR EXCHANGE OF PATIENT INFORMATION FOR NEUROFEEDBACK THERAPY I authorize and consent to the exchange by GMH staff of my, or the patient's if I am the patient's parent/guardian or responsible party, protected health information from GMH's clinical records during neurofeedback therapy, as needed, solely in accordance with their professional judgment.

By signing this Agreement, I understand the information set forth herein, and waive any claim of damages from the neurofeedback therapy, including but not limited to, the worsening of any condition for which the neurofeedback therapy was undertaken, any claimed side effects and/or the failure of the neurofeedback training to improve any existing condition. I have read and understand the terms herein, and I have had the opportunity to ask any questions I had about the terms in this Agreement. Any questions I may have had about this Agreement have been answered to my satisfaction.

_____ _____

Printed Name of Client or Personal Representative **Date**

_____ _____

Signature of Client or Personal Representative **Date**

_____

Capacity of Personal Representative (e.g. Parent, Guardian, etc.)

_____ _____

Signature of GMH Provider **Date**