The Neurofeedback Clinic

Grew, Morter & Hartye, P.A. 3141 John Humphries Wynd, Suite 275 Raleigh, NC 27612

Informed Consent for Neurofeedback Training

I authorize Grew, Morter & Hartye, P.A. to provide me/my child with neurofeedback assessment, evaluation, and training.
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 for myself.

I understand EEG biofeedback (neurofeedback) requires placement of surface electrodes on my scalp for the purpose of recording my EEG and the use of this signal to provide video displays and audio signals.

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

I understand that it is the client's responsibility and /or the caregiver's responsibility to monitor and report the subjective effects of training. Neurofeedback is based on the input from the client. It is very important that the client provide his/her feedback about the effects of the training. During the initial evaluation, the client needs to disclose accurately all information requested by GMH. Research literature indicates that there are some individuals who are unaffected by training. Though a large number of clinicians have reported their progress with clients, no representation is made that any individual client will improve from training. The training is noninvasive and appears to be a harmless procedure as far as is known at present. There are no known adverse effects reported in the literature.

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 Agreement for Neurofeedback Services

The fee for a Neurofeedback session is **$90.00** I agree to pay the neurofeedback session fee. Payment is due at the time services are rendered. Payment of fees for other services will be agreed upon prior to the provision of these services.

Cancellation Policy

Twenty-four (24) hour notice is required to cancel an appointment. The patient, or the responsible party listed in the financial agreement, is fully responsible for payment of the missed appointment fee of **$90.00**.
I agree to abide by this policy. I agree to be responsible for any charges I may incur as a result of the enforcement of this policy while I or my child is a client being evaluated, tested and/or treated by GMH staff.

Consent for Exchange of Patient Information for Neurofeedback Services

I authorize GMH staff members to exchange protected information from my clinical records with each other during case consultations as needed.

By signing this form, I understand the information set forth here and waive any claim of damages due to the training including worsening of my condition for which the training was undertaken, claimed side effects or the failure to improve with training. I have read and understand the Informed Consent for Neurofeedback Training, the Financial Agreement for Neurofeedback Services, the Cancellation Policy and the Consent for Exchange of Patient Information. This document was discussed with me and any questions I had were discussed as well.

I agree to abide by the aforementioned office policies.

Patient Name ____
Signature Date

____
Print Name

Parent/Guardian ____
Signature Date

____
Print Name

Provider ____
Signature Date